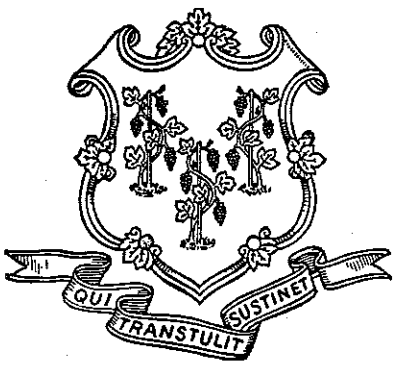
Entitlement Programs

Connecticut

General Assembly



LEGISLATIVE
PROGRAM REVIEW
AND
INVESTIGATIONS
COMMITTEE

January 1993

CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" (automatic program termination) performance reviews. The committee was given authority to raise and report bills in 1985.

The program review committee is composed of 12 members. The president pro tempore of the senate, the senate minority leader, the speaker of the house, and the house minority leader each appoint three members.

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ENTITLEMENT PROGRAMS

Legislative Program Review and Investigations Committee

January 1993

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EXECUTIVE SUMMARY

The Legislative Program Review and Investigations Committee authorized this study of entitlement programs in April 1992. The committee's primary interest was to compile an inventory of entitlement programs, outlining the state's choices and alternatives in providing those entitlements, especially those with some federal involvement. In addition, the committee was interested in the variety of entitlement programs for which an individual or family could be eligible, and the cumulative financial value of the programs.

The scope of study approved by the committee contained a definition of entitlement programs for the purpose of the study that limited the examination to entitlement programs where the state has some jurisdiction. Thus, it excluded programs where the funds and administration are totally federal, like Food Stamps, or are considered a type of insurance, like unemployment compensation. Second, the scope excluded those programs that affected the tax liability of the recipient, and educational programs administered by the Department of Education. A fuller explanation of the scope of study is included in the Introduction.

Using the definition the committee approved, 12 entitlement programs or sub-programs were identified for inclusion in the study. About half the programs are totally state-controlled; the other half involve both federal and state government.

The report contains an inventory of the programs, outlining federal and state requirements, federal options available to states operating federal programs, eligibility criteria, and benefit levels. The report also assembles caseload and expenditure information from state FY 87 through FY 92 for most of the programs, and contains an analysis of the cost of benefits provided to persons receiving cash assistance and participating in other programs as well.

The committee's findings and recommendations focus largely on the weaknesses of policy development and policy oversight concerning entitlement programs, especially those involving both federal and state government. The committee cites the absence of an overall social policy, and the lack of information and communication among the various levels and branches of government, as difficulties that face policymakers in dealing with entitlement programs. The committee proposes a number of statutory and administrative recommendations to improve the development and oversight of entitlement policy.

The committee report also highlights the operation of programs within the Department of Income Maintenance, since that agency administers the bulk of entitlements in terms of caseload and expenditures. The program review committee believes that the department should place greater emphasis on promoting client self-sufficiency, develop indicators that measure the degree of welfare dependency and identify objectives geared to reducing such dependency, and bolster prevention efforts such as the development of a plan to reduce out-of-wedlock births.

RECOMMENDATIONS

1. **The reorganization team should be given the opportunity to develop a broad social policy, and submit it to the legislature for action. If that group does not adopt one, the legislature should develop one.**

2. **The state should begin to establish a better link between state policymakers and their federal counterparts so that federal policy initiatives are conveyed to all branches of state government as soon as possible. In addition, Section 4-66a(b) of the Connecticut General Statutes should be changed to require that the secretary of the Office of Policy and Management advise the legislature through the Appropriations Committee and the chairmen of the committees of cognizance of such federal policy initiatives.**

3. **Any state agency proposing a change -- legislative, fiscal or program policy -- that would affect the entitlement programs identified in this study, shall issue an impact statement to the committee of cognizance and the Appropriations Committee, as well as other executive agencies involved, outlining the policy being proposed. This should be submitted in one of the three following ways:**

    - **with the agency's budget requests for a policy that will need legislative action and/or appropriation;**
    - **with the proposed regulations if the policy must go through the regulatory process; or**
    - **at least 60 days prior to an adoption of program policy where legislative or regulatory approval is not necessary.**

4. **The Department of Income Maintenance shall hold public hearings on the state plans for Aid to Families with Dependent Children, Medicaid, and the JOBS program at least once every three years, and that the department shall notify the committee of cognizance of those hearings.**

5. **Section 17-2k(a) of the Connecticut General Statutes shall be amended to remove the requirement that the commissioner of the Department of Income Maintenance submit an application for a federal waiver of any assistance program to the committee of cognizance for human services and the Appropriations Committee of the General Assembly, prior to submitting the application to the federal government. Instead, the commissioner will be required to notify the legislative leaders of the submission of the application to the federal government.**

6. **Sections 17-2(b) and 17-12f of the Connecticut General Statutes shall be amended to remove automatic increases to benefit payments.**

7. **The statutory goal of the JOBS program shall be expanded to include a short-term goal aimed at "reducing the level of assistance needed by helping the client obtain employment".**

8. **As part of the performance measures required under Public Act 92-8 of the May Special Session, the Department of Income Maintenance shall develop a series of indicators aimed at measuring the degree of welfare dependency in Connecticut, indicate what those rates are, and identify objectives geared to reducing such dependency.**

9. **The Department of Income Maintenance shall develop a plan for preventing out-of-wedlock births.**

INTRODUCTION

The Legislative Program Review and Investigations Committee authorized this study of entitlement programs in April 1992. The committee's primary interest was to compile an inventory of entitlement programs, outlining the state's choices and alternatives in operating the programs identified. The committee was also interested in the variety of entitlement programs for which an individual or family could be eligible, and the cumulative cost of providing those programs.

Scope

The scope of the study approved by the committee contained the definition of entitlement programs for the purpose of the study. The definition limited the examination to entitlement programs where the state has some jurisdiction. It excluded programs where the funds or administration are totally federal, like the Food Stamp program, or are considered a type of insurance, like unemployment compensation. Second, the scope excluded programs that affect the tax liability of the recipient and educational programs administered by the Department of Education. Finally, to be included in the scope of study, the program also had to:

- have defined eligibility criteria that a client must meet;
- provide a direct allocation of funds, goods, or services to a client (or a transfer payment to a third party that entitles a client to funds, goods, or services) that cannot be denied to, or taken away from the individual client due to lack of funds, or for any other reason without a hearing; and
- receive partial or total funding of at least $1 million from the state General Fund.

Using the definition the committee approved, 12 entitlement programs or sub-programs were identified for inclusion in the study. The programs, and the agencies that administer them are:

Department of Income Maintenance (DIM):

- Aid to Families with Dependent Children (AFDC);
- Aid to Families with Dependent Children -- Unemployed Parent (AFDC-UP);
- State Supplement Program (SS);
- Medicaid;
- General Assistance (GA);

- JOBS Program for AFDC Recipients; and
- Child Care for AFDC Recipients.

Department on Aging:

- Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled (ConnPACE)

Department of Children and Youth Services:

- Subsidized Adoption Programs

Connecticut Alcohol and Drug Abuse Commission (CADAC):

- Ambulance Transportation Program

Department of Education:

- School Nutrition Programs

Department of Higher Education:

- Tuition Waiver Program

Methodology

A variety of sources and research methods were used in conducting the study on entitlement programs. State statutes, state budget documents, reports issued on the programs by the administering agencies, and various caseload and expenditure documents issued by the relevant agencies were also used. Federal reports, especially the Green Book on Entitlements, which is issued annually by the U.S. House of Representatives Ways and Means Committee, was also a frequent source of information. The general literature on public assistance, welfare, and entitlements was also reviewed. (For a complete listing of sources consulted, see Appendix A).

Committee staff interviewed a number of individuals in the administering agencies about the entitlement programs they operate. In addition, the program review committee held a public hearing in September 1992 to gather testimony on the state's entitlement programs.

Report Format

The report contains five chapters. The first chapter is an overview of entitlement programs, including a brief explanation of the different types of entitlements, outlining the recent concerns about entitlements and their growth, and providing a summary overview of the

entitlement programs falling within the scope of the study. Chapter II explains the process for developing, maintaining, and amending entitlement programs, particularly for those with both federal and state entitlement involvement. Chapter III provides summarized program descriptions of each of the 12 entitlements. Included in this chapter are caseload and expenditure data and trend information, as well some comparative program data between Connecticut and other states and the nation. Chapter IV analyzes the cost of benefits of the programs being provided to recipients of the major cash assistance programs, AFDC and State Supplement. The final chapter contains the committee's findings and recommendations.

It is the policy of the Legislative Program Review and Investigations Committee to provide state agencies subject to a study to review and comment on the recommendations prior to the publication of the final report. All six agencies operating one or more entitlement programs contained in this study were given an opportunity to comment. The Department of Income Maintenance provided a written response, which is contained in Appendix F.

CHAPTER I

OVERVIEW OF ENTITLEMENT PROGRAMS

Few issues have received as much attention lately as entitlement programs. Despite all the discussion, an entitlement program has no statutory or regulatory definition. It has informally come to mean the provision of assistance -- cash, goods, or services -- for ceratin eligible persons with no total funding ceiling. In other words, the resources that support these programs are "uncapped", or limitless.

Types of Entitlement Programs

There are three basic categories of entitlement programs:

- one where an applicant must first pass a "need" or "means" test, showing that he or she does not have the means to otherwise provide for the cash, goods, or service the program offers (most types of public assistance fall into this category):

- one that offers assistance without such a "means" test, either because the recipient, or someone on that person's behalf, paid into the program at some point (e.g., social security or unemployment compensation) or because the recipient belongs to a category deemed eligible (e.g., medicare and veterans' disability); or

- one that extends no affirmative assistance, but the entitlement reduces in some way the financial obligation (i.e., a tax or a fee) the recipient has to pay to the government because the individual belongs to a category of eligible persons or has ceratin expenses that qualify for reducing his or her taxes or fees. The mortgage interest deduction and the elderly and veteran's tax credits are examples of these entitlement programs.

Who Benefits From Entitlements

Just as there is no standard definition for what an entitlement is, there is also no consensus about who benefits most from entitlements. The recipients who benefit from entitlements are not confined to a single category or population group in society. The elderly, the poor, the disabled, students, veterans, and the middle class all benefit to some degree from entitlements.

Concern Over Entitlements

The broad coverage of entitlement programs and the benefits they distribute to society, are the primary difficulties in controlling their use. Discussions of limiting benefits or imposing stricter eligibility criteria can lead to emotional debates, pitting one group or generation against another. Yet the discussions and the debates continue because policymakers at all levels of government, as well as the general public, are concerned about the effects and the costs of entitlement programs. Some of the concerns are summarized below.

Fiscal. Entitlement programs consume much of the federal budget and correspondingly add to the federal debt. In federal fiscal year (FFY) 90, federal contributions alone totalled $31.7 billion and $260.9 billion on the means- and nonmeans-tested cash assistance respectively. This, combined with other noncash assistance programs (many of which are entitlements, like medicaid) amounted to almost 30 percent of the federal budget, and almost 7 percent of the country's Gross National Product (GNP).[1] Most of the spending has been for Social Security, where in constant 1990 dollars, the costs of the program have gone from about $184 billion in 1980 to $243. billion in 1990, an increase of 32 percent.

Other types of cash assistance programs (e.g., AFDC, Supplemental Security Income) grew less dramatically -- from $27.8 billion to $31.6 billion in 1990 dollars, or 13.6 percent over the decade. The largest growth area, however, was in the noncash component (Medicaid, food stamps, and nutrition programs), which grew by an inflation-adjusted rate of 46.2 percent -- from $55.5 billion to $81.2 billion -- over the decade. Medicaid alone cost $41.1 billion in FFY 90.

Fiscal distress from entitlement programs is not isolated to the federal level; states also feel the impact. Though most entitlement programs are federally reimbursable to some degree, entitlement program expenditures can significantly impact a state's spending in tight fiscal situations, thus leaving fewer options to state policymakers to balance their budgets. In fact, while the total expenditures for entitlement programs are ceratinly less in each state than at the federal level, the percentage of individual state budgets allocated for needs-tested entitlements is larger than the federal portion, and growing.

Spending on Medicaid illustrates the impact on state budgets. According to data on state expenditures collected by the National Association of State Budget Officers, 24 states spent less than 10 percent of their budgets on Medicaid in FY 89; by FY 91 the number of states had dropped to 12. In contrast, in FY 89 only 9 states spent more than 12.5 percent of their budgets on Medicaid, but by FY 91 that number increased dramatically to 24 states. The fiscal impact on Connecticut's budget will be discussed later in this chapter.

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[1] Congressional Research Service. Progress Against Poverty in the United States (1959 to 1989), Washington, D.C., April 1991.

Social policy. There is general consensus that the objectives of public assistance entitlement programs are to reduce poverty without creating dependence on assistance and to encourage economic self-sufficiency. But there is less agreement about how these programs should achieve that. Hence, legislation and regulations dealing with entitlements are frequently amended to: create greater work incentives; establish support mechanisms to allow more people to work; target benefits to those who need them most; and achieve benefit adequacy.

Many of the entitlement programs were begun through a partnership of federal and state governments. However, there is also much disagreement about which level of government is the most appropriate to decide those issues and set social policies. The social policy issues lead to another concern about entitlement programs -- the expanding mandates and regulations required by the federal government.

Mandates and regulations. Since the early 1980s, there has been tremendous growth in federal legislation and regulations that has impacted both entitlement and nonentitlement programs at the state and local level. In April 1992, the Advisory Commission on Intergovernmental Relations issued a study, and among its key findings were:

1) Despite concerted presidential action to control federal rule-making activity, the burdens imposed on state and local governments by administrative rules and regulations continued to increase during the 1980s;

2) Between 1981 and 1990, Congress enacted 27 statutes that imposed new regulatory burdens on states and localities, or significantly expanded existing programs, which in some ways surpassed the unprecedented intergovernmental regulation of the 1970s; and

3) The federal government should, but does not, know the cumulative financial costs imposed on state and local governments by recently enacted federal mandates. Available evidence indicates, however, that such costs are substantial and growing at a faster rate than overall federal aid.[2]

Furthermore, entitlement programs are especially prone to modification because normal fiscal controls --limiting appropriations or cutting a budget -- cannot be applied. Instead, laws or regulations that establish eligibility criteria, benefit levels, and the like must be changed in order to control costs.

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[2] Advisory Commission on Intergovernmental Relations. Federal Regulation of State and Local Governments: Regulatory Federalism -- A Decade Later, Washington, D.C., April 1992. pp. IX-2 - IX-5.

The trend in increasing mandates on states is unlikely to diminish. The National Conference of State Legislatures issues a monthly watch list of mandates proposed by Congress that would, if enacted, affect state or local governments. By June 1992, the 102nd Congress had proposed 196 such mandates, a great number modifying entitlement programs. While certainly many of these will never become law, it is an indication that federal legislation affecting other levels of government is likely to continue.

The direction for entitlement programs appears to be greater federal pressure on the states to expand the programs, broaden the groups they serve, and increase benefits to recipients. Of course, this lessens the options and the discretion that states have in providing these programs, decreases state operational control, and heightens the fiscal constraints on states to pay for the programs.

A Summary Profile of Entitlement Programs in Connecticut

All of the entitlement programs under review, with the exception of the Tuition Waiver program and the Subsidy Program for Adoption of Children with Special Needs, are income- or needs-based. As stated earlier, this does not mean that all entitlement programs only benefit the poor, or that these programs are the costliest. However, these are the programs in which state government has some policy and fiscal role. Beyond that, the programs are diverse in the populations they serve, the income limits they set, the assets and expenses the recipients are allowed, the benefits they offer, and which level or branch of government establishes programmatic requirements.

Populations served. It is difficult to state with any accuracy the total number of state residents being served by one or more of the programs included in the study because some recipients are served by multiple programs, but hard data on that are not available. The best estimate is 10 to 15 percent of the state's 3.28 million population is served by at least one of the programs under review. The estimate is based on the following FY 92 unduplicated program figures:

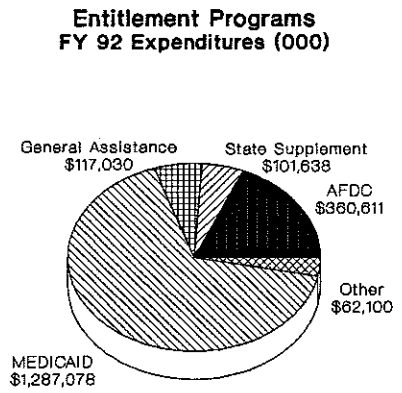
- 241,000 eligible clients under the Medicaid program, which includes those receiving cash assistance from other programs like AFDC or State Supplement;
- 35,000 General Assistance recipients;
- 5,000 recipients of the Tuition Waiver program (assuming about half the actual number of tuition waivers granted for FY 92, since the numbers of waivers could be granted to the same person over the two semesters);
- 53,300 recipients in the ConnPACE program; and

- 20,000 recipients who participate in the reduced-price lunch program (assuming conservatively that all children receiving free lunches are also receiving AFDC).

Cost of the programs. With the exception of the Tuition Waiver program, which is paid from fees charged to all students, each of the programs receive at least $1 million from the General Fund. Together, the General Fund expenditures for these programs total approximately $1.9 billion, or about 20 percent of the state's FY 92 estimated expenditure Figure I-1 is a comparative breakdown of the expenditures on the entitlement programs under review.

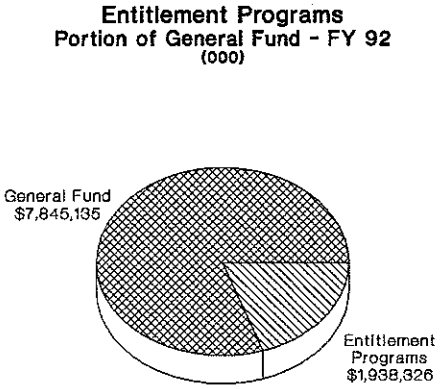
Figure I-2 shows the entitlement program expenses as a portion of all General Fund spending. It is important to note that these total expenditures and their corresponding percentages of the state budget are before any federal reimbursement. As noted in each of the program descriptions in Chapter III, at least 50 percent of the costs are federally reimbursable for most of the programs. Thus, while these monies must be appropriated through the state budgetary process, and certainly affect the final budget amount, the financial impact is softened considerably by the reimbursements.

Figure I-1.



Source: Connecticut State Budget
Office of Fiscal Analysis

Figure I-2.



Source: Connecticut State Budget
Office of Fiscal Analysis

CHAPTER II

ENTITLEMENT PROCESS: FEDERAL/STATE PROGRAMS

Introduction

There is no one process that Connecticut follows to develop, maintain, or amend the entitlement programs under review in this study. The operational dynamics of the programs vary by the mix and scope of governmental authority relevant to each program. Thus the parameters within which the state operates and the span of control the state has over each program vary also.

Table II-1 below arranges the programs by type and level of relevant government authority. Four of the programs -- General Assistance, CADAC Ambulance Transportation, ConnPACE, and Tuition Waiver -- are authorized, funded, and administered solely by the state. The state, therefore, has total discretion over these programs. The remaining five -- AFDC and its subprograms, Medicaid, State Supplement, School Nutrition, and Subsidized Adoption -- involve both the federal and state governments. (The subsidized adoption program has a component that is totally state-administered and funded for certain children, a split reflected in the table.)

Table II-1. Entitlement Programs by Type and Level of Government Authority.

	Cash Assistance	Medical Services	Goods/Other Services
Federal/ State	- AFDC - State Supplement - Subsidized Adoption Program	- Medicaid - Subsidized Adoption Program	- School Nutrition Program
State	- General Assistance - Subsidized Adoption Program	- General Assistance Medical - ConnPACE -Subsidized Adoption Program	- Tuition waivers - Ambulance Transportation (CADAC)

This section focuses on the processes related to programs involving the federal government, with emphasis on AFDC and Medicaid.[3] AFDC and Medicaid are examples of

[3] The State Supplement program is totally state-funded, but operates under some federal strictures, which differ from the schemes in the AFDC and Medicaid programs. State supplement will be discussed in this section where instructive.

"cooperative federalism"[4], where the federal government establishes a program with: 1) a framework of requirements, both administrative and substantive; and 2) areas of state discretion. The federal requirements include those in statute and in regulations promulgated by the pertinent federal agencies. In exchange for voluntary state participation, program administration, and state funding, the federal government provides significant matching funds.

Actors. Before the methods of interaction between the federal and state government are discussed, the main actors in the process will be identified. Congress, of course, with presidential approval, enacts and amends the statutes that set out the framework for the AFDC and Medicaid programs, all in separate titles of the federal Social Security Act (SSA).

The Department of Health and Human Services (HHS) is the federal agency charged with implementing the laws, including promulgating regulations to carry out the statutory purposes, as well as monitoring state compliance with the federal law. The department has sub-entities including the Office of Family Support (responsible for AFDC), the Health Care Financing Administration (responsible for Medicaid), and the Social Security Administration (responsible for State Supplement).

Each state legislature is involved in decisions about state participation in the AFDC and Medicaid programs. In Connecticut, the Joint Committee on Human Services is the panel with subject matter jurisdiction over the state AFDC and Medicaid programs. The Joint Committee on Appropriations has jurisdiction over any aspect involving expenditures. In terms of administration, each state must designate a single state agency to administer the program. In Connecticut, the Department of Income Maintenance is that agency. DIM is responsible for developing, planning, and running the programs, including drafting and adopting policy regulations.

When needed, DIM will seek legal advice from the Office of the Attorney General. In addition, the state subscribes to an advisory service to keep abreast of pertinent cases impacting the AFDC and Medicaid programs.

Finally, the courts may be involved in making determinations about whether actions by the state or the federal government comport with the statutory intent of Congress, or whether any action violates constitutional principles. Suits may be brought by a wide variety of plaintiffs, such as recipients of public assistance, states, and institutions providing medical services under Medicaid.

The processes within which these actors interrelate are detailed next. These processes involve both administrative and substantive features of the programs.

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[4] King v. Smith, 392 U.S. 309 (1968)

Process: Administrative and Substantive

State plans. The primary link between the states and the federal government in the AFDC and Medicaid programs is the state plan, a document required of the states for each program in order to receive federal matching funds. The federal Social Security Act sets out the required content of the state plan, which, besides dictating administrative requirements, lays out the substantive mandatory and optional components of the state's AFDC and Medicaid programs.

As described in federal AFDC regulations, the state plan:

> ...is a comprehensive statement submitted by the state agency describing the nature and scope of its program and giving assurance that it will be administered in conformity with the specific requirements stipulated in the [federal statute], the regulations and other applicable issuances of the Department. The state plan contains all information necessary for the administration to determine whether the plan can be approved, as a basis for federal financial participation in the state program.

Mandatory and optional features. The federal statutes establish certain mandatory components in both the AFDC and Medicaid programs, provide states the option to elect certain other components, and leave some features up to the states' discretion. Absent some specific provision to the contrary, as long as a program is optional, a state electing the option may choose later to eliminate the option without consequence from the federal government.

Sometimes, features that were previously optional become mandatory pursuant to change in the federal law. These changes, of course, come about through the federal legislative process in which the states' interests represent one of many voices in the political mix. To the extent the federal requirement coincides with state policy reflected in the decision to offer certain coverage when optional, concern about decreasing state discretion is minimized.

However, if, for example, the state policy decision needs to be revised in light of changing fiscal times, the state is in a more difficult position. A state has the authority to refuse to provide mandatory coverage under AFDC or Medicaid, but must remove itself from the entire program as a result, and thus forego federal funding.

The history of the AFDC-UP (unemployed parent) program illustrates how an optional program becomes mandatory. Between 1935 and 1962, the AFDC program was strictly geared toward needy children who had only one parent in the household. (There could be two parents if one was disabled). In 1961, federal law was amended to allow states the option of giving AFDC to two-parent families where a parent was unemployed (with some rules about acceptable circumstances of the unemployment).

As of 1988, a little more than half of the states, including Connecticut, offered the optional coverage. Via the 1988 federal Family Support Act, the Social Security Act was amended to require all states participating in AFDC to provide AFDC-UP. As noted in the AFDC program description in Chapter III, the requirement was applied differently to states depending on if the state had optional coverage for unemployed parents before mandatory coverage was imposed.

Another area that has evolved from optional to mandatory is the treatment of pregnant women under Medicaid. The 1980s saw incremental shifts from optional to mandatory treatment for these women, with changing eligibility provisions related to income.

Maintenance of effort. In addition to mandating previously optional programs, other federal legislative action affects state discretion. "Maintenance of effort" provisions have been enacted, where the maintenance of a certain expenditure level in one program is linked to continued receipt of federal funds in another.

Maintenance of effort provisions are federal attempts to encourage state payment behavior, in light of the fact that decisions about the actual amount of cash assistance paid to recipients of AFDC and state supplement have historically been left up to the various states. Thus, AFDC cash benefits for a family of three can range from $124 in Alabama to $891 in Alaska[5]. Likewise, individual state supplemental benefits can range from $2 in Oregon to $362 in Alaska[6].

In a few different situations, the SSA has been amended to effectively impose a floor on the level of benefits offered in AFDC and State Supplement by linking receipt of Medicaid funding with compliance with these floors. The actual benefit level a state may not go below reflects the state's effort up to the pertinent date. There are two primary "maintenance of effort" provisions currently: the AFDC/Medicaid link and the SSI pass-through provision.

AFDC/Medicaid link. Since 1965, the federal Medicaid statutes prohibited the secretary of health and human services from approving a Medicaid plan if he or she "determine[d] that the approval and operation of the plan will result in a reduction in aid or assistance in the form of money payments... provided for eligible individuals under an [AFDC] plan". The 1988 Medicare Catastrophic Coverage Act (MCCA) amended that language to read: " the Secretary shall not approve any plan for medical assistance if the state has ... [AFDC] payment levels that are less than the payment levels in effect under such plan on May 1, 1988."

The amendment resulted from concern that another MCCA requirement -- that states provide Medicaid coverage to pregnant women (and their babies under one year old) whose

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[5] U.S. House of Representatives, Committee on Ways and Means, 1992 Green Book: Overview of Entitlement Programs, (May 1992) (figures as of November 1991).

[6] 1992 Green Book (figures as of January 1992 for individuals living independently).

incomes were no greater that 100 percent of the poverty level,[7] -- would result in states offsetting their increased Medicaid costs by lowering their AFDC expenditures. Since 1986, this coverage had been optional for the states. Since 1981, coverage was optional at lower income levels. The exact meaning of this 1988 AFDC floor language is now being litigated in federal court.

SSI pass-through. There is also a maintenance of effort provision affecting the State Supplement program, which is related to the federal Supplemental Security Income (SSI) program. Brief information about these programs is provided here to explain the maintenance of effort issue; more detailed information is in Chapter III.

The SSI program is a totally federally funded and administered cash assistance program for the aged, blind, and disabled. States are involved in two ways. First, when SSI was established in 1972, replacing joint state/federal programs, federal legislation was passed requiring states to continue paying benefits to those program recipients already receiving assistance to make up any benefit reduction resulting from the federal takeover of the program. This was mandatory state supplement, encouraged through a link between those payments and continued state eligibility for Medicaid funding.

Second, also in 1972, Congress suggested states provide optional supplemental aid to SSI recipients and others, and offered to administer these programs under certain circumstances. The funds for these supplemental payments come totally from the states. Forty-eight states provide such payments.

Federal law provides for annual cost-of-living increases to SSI payments. In 1976, after the SSI program had been operational for two years, federal concern was raised over the practice in certain states of reducing their state supplements at the same time the federal cost-of-living increase was paid. The effect, according to one court, was that: "SSI recipients in those states have been denied the full benefit of the cost of living raises approved by Congress. Instead the increased federal expenditures have gone to provide fiscal relief to the states". Oklahoma v. Schweiker, 655 F.2d 401, 404 (1981).

In response, Congress legislated a pass-through provision, which placed requirements on states to remain eligible for Medicaid funding. States must continue to pay state supplements, at benefit levels not to fall below the payment levels in effect in December 1976. Congress provided that a state was in compliance if total expenditures in a one-year period did not go below total expenditures for the previous year.

Soon after this pass-through provision was enacted, 13 states challenged the constitutionality of this provision in part on the grounds that it violated the federal spending power. In 1981, a federal appeals court upholding the provision stated:

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[7] In 1990, Congress raised the mandatory poverty level percentage to 133 percent, with coverage up to 185 percent optional for the states.

> [The challenging states] observe that none of Congress' enumerated powers permit it to require the states to devote a certain portion of their budgets to welfare programs. And they insist that the result may not be accomplished indirectly via the terms imposed by the pass-through condition, which is not related to the federal spending program conditioned, that is, Medicaid....
>
> We note initially that Congress' lack of authority to mandate directly the result it hopes to encourage by means of the pass-through provision is not an appropriate measure of congressional jurisdiction under the spending clause. The Supreme Court has long recognized that the power to spend for the general welfare is not limited by the direct grants of congressional power enumerated in article 1. Rather, the general welfare clause is itself an independent--and expansive source of Congress' spending authority....
>
> We find the pass-through provision a conventional and appropriate exercise of Congress' authority under the spending clause. Oklahoma at 405, 416-417.

Because of recent changes in Connecticut's State Supplement program, there is some concern that based on SSP expenditures during calendar year 1992, the state might be in noncompliance with the pass-through statute. A note to the DIM budget in the state FY 93 budget book prepared by the Office of Fiscal Analysis (OFA) cautioned: "It should be noted that maintenance of effort requirements may substantially alter the savings possible [through 1992 rate restructuring and income disregard provisions] unless the Department asks for a waiver from [the Health Care Financing Administration]."

Amending the state plan. If a state decides to exercise an option or change some other discretionary aspect of AFDC or Medicaid, it must submit an amendment to its state plan to the Department of Health and Human Services for approval. The plan also must be amended to reflect federally required changes. As noted in federal regulation:

> ...after approval of the original plan by the administration, all relevant changes, required by new statutes, rules, regulations, interpretations, and court decisions are required to be submitted currently so that the administration may determine whether the plan continues to meet federal requirements and policies.

The impetus for a voluntary change in the state program may come from either the state legislature or DIM. If the change will have a budget impact, the department submits the proposed change as a budget option during the appropriations process. Specific authorizing language might be submitted as legislation also.

In considering an option or some other voluntary change to either the AFDC or Medicaid programs, the department will attempt to estimate any potential cost to the state. If a change is approved, either through the appropriation process alone or with substantive statutory change,

DIM will promulgate policies to carry out the new or revised program as needed. By state statute, all DIM policies are developed in regulation form (except for internal administrative policies), and go through the regulation review process, providing all the opportunities for comment normally afforded under the Uniform Administrative Procedure Act. Since 1990, agencies proposing regulations have been required to specifically notify the subject matter committees of any such pertinent regulations. In the case of AFDC, Medicaid and State Supplement, the statutes provide that the state may operate under policy that is in the regulation review process, as long as DIM provides certain notice of the intended regulations.

Waivers. As noted in the introduction, views on how best to achieve the objectives of the AFDC and Medicaid programs differ. Since 1962, the SSA has provided for an administrative waiver of state plan requirements for states to engage in experimental, pilot or demonstration projects if the projects are "likely to assist in promoting the objectives of the [AFDC and Medicaid] programs." A common state plan element sought to be waived is the statewideness requirement, because demonstration projects are conducted in target areas. If a state is interested in conducting such a project, it submits an application to the federal agency for its approval.

In addition to the administrative waiver process, in certain circumstances, Congress will direct through legislation that certain provisions be waived so that specified demonstration projects can be conducted. Congress also provides permanent programmatic waivers in specified areas to all states.

One public affairs journal observed: "states have only been encouraged to seek [waivers] for welfare reform since the Reagan Administration."[8] In material prepared for a congressional working group on welfare, it was noted: "The debate over waivers and the waiver process seems to divide discussants according to which level of government they perceive as likely to do the best job designing welfare programs--the states versus the federal government."[9] As of October 1989, 25 states had demonstration projects in effect.[10]

Demonstration waivers are for set time periods and of limited scope. Waivers are not designed to be the avenue for a state to permanently alter its AFDC or Medicaid program. Based on the demonstration experience, Congress may be encouraged to amend the Social Security Act to make the project components either an option or a new program requirement for all states. If this does not happen, when the demonstration period is over, the state program goes back to the way it was, unless an extension is given.

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[8] States Bypassing Congress In Reforming Welfare, CQ, April 11, 1992, p. 952.

[9] New Directions: Welfare Reform in Twelve States, The House Wednesday Group, U.S. House of Representatives, August 1, 1992, p. 6

[10] Characteristics of State Plans for AFDC, 1990-1991 Edition

Traditionally, the waiver approval process could take several months to be completed. In early 1992, President George Bush announced an expedited waiver review process requiring only one month. Projects under waivers must be cost neutral to the federal government and subject to extensive evaluation.

The cost neutrality provision means if the costs of the demonstration project to the federal government under the federal match provision exceed what would have been spent by the federal government under the normal program, the state pays the excess. The evaluation component consists of three elements: a process study, a cost-benefit analysis, and a formal impact evaluation.

A Connecticut legislative approval process for state waivers of federal assistance requirements was enacted in 1985. The DIM commissioner is to submit any federal waiver application to the Appropriations and Human Services Committees first. These committees have 30 days to approve, deny, or modify the application. If the two committees do not agree, a conference committee made up of members from each is appointed. The conference committee reports to the Appropriations and Human Services committees, which either accept or reject the report. If either committee rejects the conference report, the application is deemed approved.

If the committee accepts the report, the appropriations committee advises the DIM commissioner of its approval, denial, or modification of the application. (If the committee does not act within 30 days, applications are deemed approved).

This statutory provision has not been used for demonstration waivers to date. Public Act 92-79, effective October 1, 1992, however, requires the DIM commissioner to seek a waiver of the 30-month transfer-of-asset rule under Medicaid, in order to use a 60-month period. The purpose of the waiver is to "establish...a means of reducing longterm care costs under the Medicaid program." Additionally, under Public Act 92-16 enacted during a May 1992 special session, the commissioner is directed to seek a waiver to allow a minor who is an AFDC recipient "to retain assets for future identifiable education expenses."

Also, the Welfare Reform Task Force, established by P.A. 92-16, is scheduled to issue a report to the General Assembly in mid-January 1993. The group is completing its work now, and some of the proposals being discussed would require the state to seek waivers of certain AFDC rules. According to the department, the plan is to bundle a variety of waivers together for a demonstration project.

Appendix B contains summaries of some demonstration projects currently being conducted by various states, for which federal waivers were recently obtained. Essentially, states are experimenting with a variety of incentives (some positive, some negative) to see what impact the incentives might have on AFDC recipients. For example, some states impose financial sanctions on families whose school-aged children have poor school attendance. Other states are experimenting with not paying additional AFDC benefits for children born to families on assistance.

Demonstration projects utilizing federal law waivers also are conducted under the Medicaid program. Many of the current projects involve the use of a managed care focus. Well-publicized is Oregon's demonstration proposal, under which the numbers of persons who would be covered are greatly expanded and a basic set of benefits is offered.

Judicial review. As with any public effort for which guidelines are established in statute and regulation, disputes arise about these provisions and how they are carried out. If a state disagrees with an action taken by HHS with respect to AFDC or Medicaid, it may appeal for reconsideration by the agency. If the action is still in dispute, the state may appeal the agency decision to a federal appeals court.

Individuals have no avenue through the federal administrative agency if they think a state program is in violation of the requirements of the federal statutes or the U.S. Constitution. Thus, they must file suit in court. Generally, the courts will attempt to resolve any issues on statutory interpretation grounds without reaching constitutional issues.

The U.S. Supreme Court has never found that the receipt of public assistance in and of itself is a constitutional right. The court has found that if governments choose to run such programs, certain constitutional protections come into play. An example of an issue resolved by the courts on constitutional grounds involved the question of whether a state could require individuals to actually live in a state for at least a year before being eligible for public assistance. The Supreme Court held in Shapiro v. Thompson[11] that while it was permissible for a state to require actual residence, a durational requirement violated the constitutional right to travel.

Last year, the General Assembly leadership requested an opinion from the attorney general about whether a durational residency requirement could be instituted in GA cases. Citing the Shapiro case and others, the attorney general advised that such a requirement would be unconstitutional.

Recently, under demonstration waivers, states are experimenting with policies whereby new residents, for a certain period of time, are eligible only for the level of benefits they would have received in the state from which they have just moved. The Department of Health and Human Services has approved projects with these provisions (California and Wisconsin) and has apparently received advice from the U.S. Justice Department that this distinction would survive a durational challenge. Meanwhile, a court in a Minnesota case testing a similar provision found the practice impermissible; the case is being appealed.

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[11] 394 U.S. 618 (1969)

CHAPTER III

PROGRAM DESCRIPTIONS

This chapter contains information on each of the entitlement programs that were determined to fall within the scope of the program review committee study. The programs and the administering agencies are:

Department of Income Maintenance:

- Aid to Families with Dependent Children;
- Aid to Families with Dependent Children -- Unemployed Parent;
- State Supplement Program;
- Medicaid;
- General Assistance;
- JOBS Program for AFDC Recipients; and
- Child Care for AFDC Recipients.

Department on Aging:

- Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled (ConnPACE)

Department of Children and Youth Services:

- Subsidized Adoption Programs

Connecticut Alcohol and Drug Abuse Commission:

- Ambulance Transportation Program

Department of Education:

- School Nutrition Programs

Department of Higher Education:

- Tuition Waiver Program

As much as possible, the program descriptions present similar information about each of the programs in a similar format. However, since the programs are varied in terms of the populations they serve, how they operate, and what benefits they offer, this was not always possible. Where the program has federal requirements and federal options, those are presented in exhibits immediately following each relevant program description.

AID TO FAMILIES WITH DEPENDENT CHILDREN

Purpose: To provide cash payments to families who are unable to support their children because a parent is dead, absent, physically or mentally disabled, or unemployed.

Administering agency: State Department of Income Maintenance

Statutory authority: Sections 17-85 to 17-134 of Connecticut General Statutes, and Title IV-A of the Federal Social Security Act

Federal requirement: There is no federal requirement that a state must participate, but if it does, then it must follow specific program mandates. The specific federal requirements are outlined in Exhibits AFDC-1 through AFDC-6.

Federal reimbursement: The federal government reimburses between 50 percent to 80 percent of a state's AFDC program costs, based on a formula that includes the state's per capita income. Connecticut is reimbursed 50 percent.

Benefits levels: There is no federal requirement about how much a state should pay to its AFDC recipients. Each state establishes its own "standard of need", which is the amount each state determines is needed to meet minimal monthly living expenses. Need is established based on the family size; in Connecticut the standard of need is $581 for a family of three in most areas of the state. Each state also sets a benefit level or a percentage of the standard of need that it will pay. Connecticut is one of 17 states that pays 100 percent of the standard of need.

AFDC case: An AFDC case is comprised of an assistance unit, which generally means the parent or other caregiver and the dependent children.

State caseload (FY 92 Average Monthly): 53,074 cases for AFDC; 1,965 cases for its subprogram AFDC for Unemployed Parents. Total average monthly cases was 55,039.[12] Total average monthly recipients under both programs for FY 92 was 155,222.

Average cost per case (assistance unit) -- FY 92: $566.21 for AFDC; $665.41 for AFDC-UP

Maximum benefit level (Family of Three): $680 for Region A; $581 for Region B; and $573 for Region C. (See Appendix D for map of regions.)

Total expenditures -- FY 92: $360,610,971

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[12] Department of Income Maintenance. Public Expenditure Reports, 1992.

Broad eligibility criteria: The family's (assistance unit's) gross income (excluding AFDC assistance) must be less than 185 percent of the state's standard of need -- $1,258 a month for a family of three -- and there must be a dependent child in the unit. Assets (e.g., bank accounts or property) cannot exceed $1,000, excluding a car valued at $1,500 or less. In Connecticut, a lien is attached to a house after the 4th month. Once it has been established that the applicant meets the broad eligibility criteria, the applicant unit must then show that its income minus certain expenses is less than the "standard of need", or what the state has determined is needed to purchase essential items. (More detailed eligibility criteria are contained in Exhibits AFDC-1 through AFDC-6. Components of standard of need are included in Appendix C.)

Eligibility criteria: Automatic eligibility for Medicaid, and for most AFDC households Food Stamps. The assistance unit may also be eligible for other programs, depending on circumstances.

Redetermination: Most cases are redetermined once every six months, or whenever changes occur in the assistance unit.

Benefit level increases: There are no federal requirements that states must increase the standard of need or the level of payments made. However, since 1988, Connecticut is mandated by state statutes to increase its AFDC payments by the same percentage increase as the increase in the Consumer Price Index for Urban Consumers. (**NOTE**: For the past two years, the legislature has not authorized the AFDC payment increases).

Caseload profile: Some characteristics of the Connecticut AFDC unit for FY 92 are[13]:

- the most common family size is two members (38.2 percent);
- the most common age of a child is age one or less (16 percent);
- the mean age of the recipient head of household is 30 years old;
- almost half (49.7 percent) of the families have been on AFDC for less than two years (for that episode), but the average length of time on AFDC is 3.4 years;
- the mother has never married (67.7 percent)[14];
- the family lives in unsubsidized rental housing (64.7 percent);

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[13] DIM Draft Report on Demographics of AFDC Caseload, 1992.

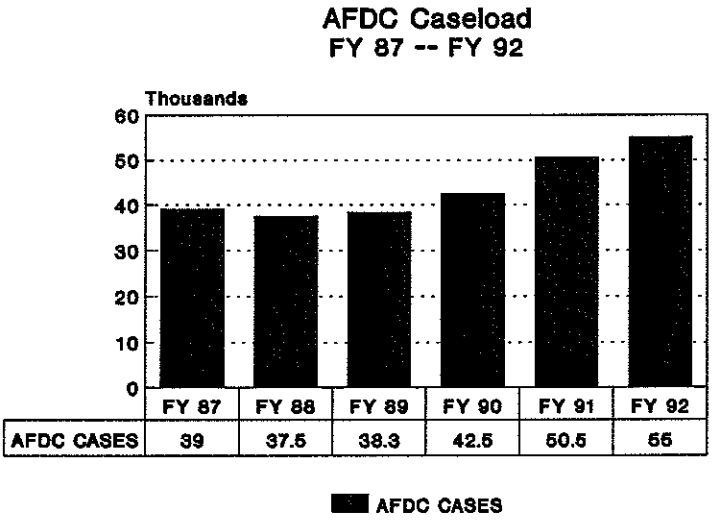
[14] 1992 Green Book on Entitlements.

- almost half of the families (46.7 percent) live in one of the state's three largest cities;
- the families are about evenly divided among Black (32.3 percent), White (33.3 percent), and Hispanic (33.6 percent); and
- most of the families (88 percent) also receive Food Stamps.

Trends in Connecticut:

Caseload: Figure III-1 depicts the state's total AFDC (including AFDC-UP cases) annual caseload for FY 87 to FY 92. As the figure shows, the caseload declined by approximately 4 percent from FY 87 to FY 88. However, from its low point in FY 88, the caseload has increased about 46 percent, including a jump of nearly 20 percent in FY 91. In FY 92, AFDC cases account for 96.5 percent of the total; the remaining 3.6 percent are AFDC-Unemployed Parent cases.

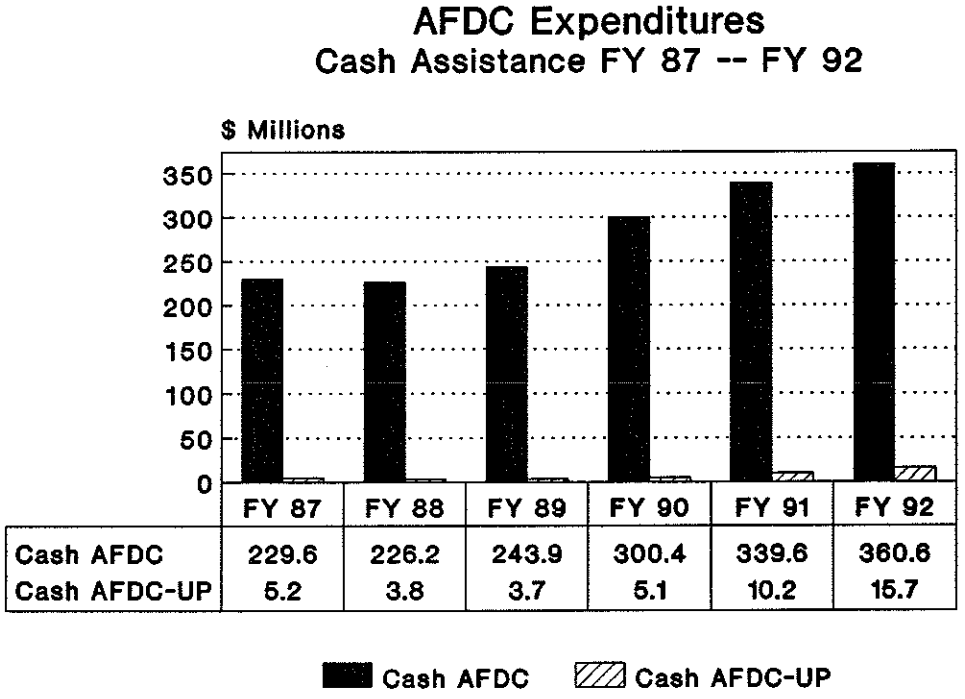
Figure III-1.



Source: Governor's Budgets
(AFDC and AFDC-UP Average monthly cases)

Expenditures: As depicted in Figure III-2, Connecticut's total cash expenditures for AFDC have grown by $141.5 million over the past five years. Medical expenses are also covered for AFDC clients, but they are discussed in the Medicaid program description. AFDC cases accounted for 92.6 percent of the increase ($131 million) and AFDC-UP the remaining 7.4 percent ($10.5 million), although the rate of increase in expenditures for AFDC-UP cases (210 percent) was over 3.5 times as great as the growth in AFDC cases.

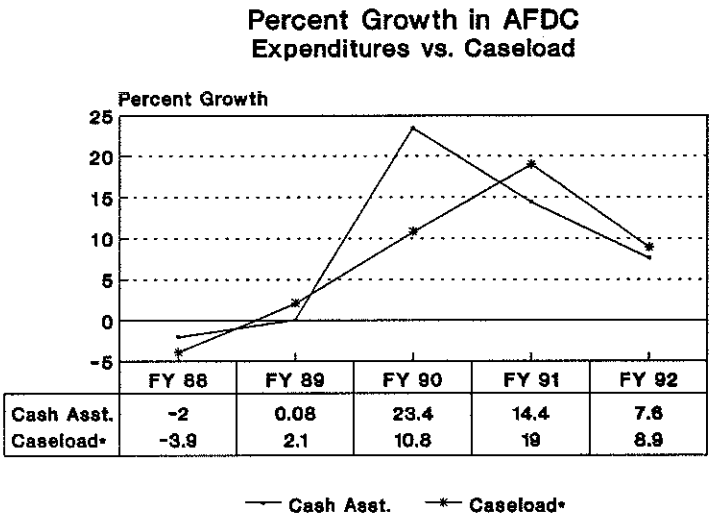
Figure III-2.



Source: Governor's Budgets and DIM Reports

Caseload and expenditure trends: Figure III-3 illustrates the rate of growth in AFDC caseload compared with the growth in cash assistance. Until FY 90, growth in cash assistance had generally outpaced the caseload growth. In fact in FY 90, the percentage growth in cash benefits was double the percentage increase in the number of cases. However, benefit levels have been frozen at FY 90 rates so while expenditures in cash assistance have still been growing, the increases have been due to growth in the caseload.

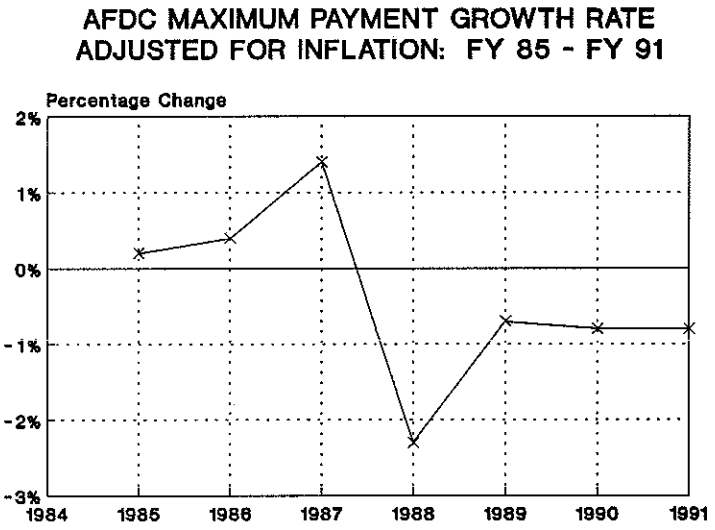
Figure III-3.



Source: Governor's Budgets
*all cases including AFDC-UP

The value of AFDC cash benefits: Even though the expenditures for AFDC cash assistance continue to grow, the individual AFDC family has seen the value of its benefits shrink. As was pointed out, the levels of assistance have been frozen at FY 90 amounts. Those capped levels, together with a small decline in the number of persons per unit, have contributed to smaller assistance checks. To gauge the trends in actual AFDC benefits, program review examined how inflation has affected the AFDC cash assistance, and how that cash assistance compares with the median income of households in the state. Figure III-4 shows the changes in the inflation-adjusted

Figure III-4.

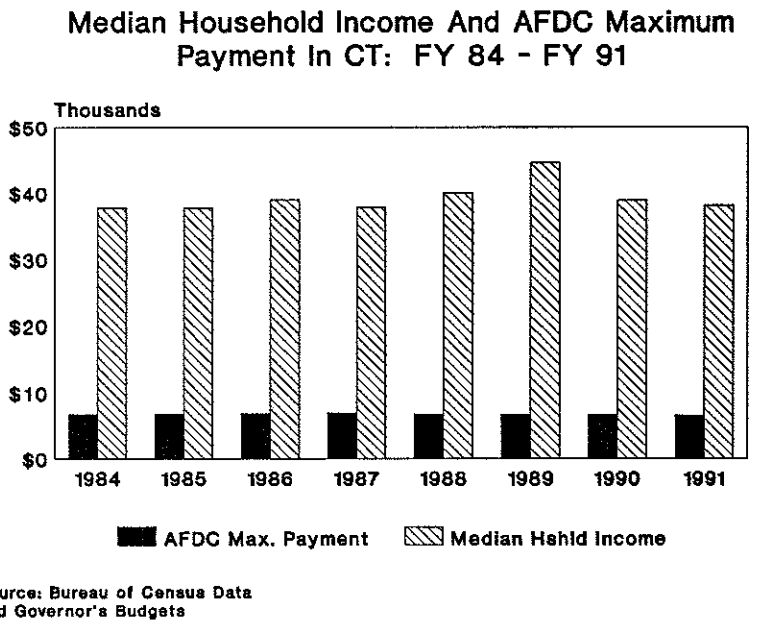


Source: Bureau of Census Data
and Governor's Budgets

growth rate of the state's maximum AFDC payment for a family of three projected over one year. The figure indicates that, after increasing in FY 85, FY 86, and FY 87, the rate took a sharp drop in FY 88 and has remained negative. Thus, the real purchasing power of the typical AFDC family has declined for four consecutive years.

Figure III-5 compares that same AFDC maximum assistance for a family of three, projected over a year, with the state's median household income from 1984 to 1990. In order to discount for the effects of inflation, both incomes have been translated into 1990 dollars. The figure illustrates the disparity between the state's median household income level and the assistance to a typical AFDC family. During the period, the AFDC cash benefits, as a percent of the state's median household income, ranged from approximately 15 to 18 percent.

Figure III-5.



Connecticut's AFDC Program: A Comparison With Other States

Recipients. As was noted above, Connecticut's AFDC caseload has increased over the past few years. But Table III-1 examines the growth from a different perspective and shows that the state's AFDC recipients, as a percent of the state's total population, has not changed much since 1975. However, if the caseload growth is examined from its low point in 1988, when the nation was enjoying a robust economy, the "percent-of-population" increased a full percent by 1991, an expansion of almost one-third in three years. Connecticut has had a lower percent of its population receiving AFDC than the rest of the nation during the entire period, but the increase in the recipient rate during the 1988-1991 period in Connecticut was 31.2 percent, well above the national increase of 12.4 percent.

TABLE III-1: AFDC Recipient Rate As Percent Of Total Population And Percent Change In Average Monthly Number of AFDC Recipients for Selected Years.

YEAR	CT.		National Average	
	Average Monthly Number of Recipients (000)	Percent of State's Population	Average State Monthly Number of Recipients (000)	Percent of Population
1975	129.7	4.2	221.6	5.2
1988	106.8	3.3	214.1	4.4
1991	142.7	4.3	246.9	5.0
1988-1991 % Change	33.6	31.2	15.3	12.4
1975-1991 % Change	10.1	3.1	11.4	-4.8

Source: U.S. Congress, House Ways and Means Committee, 1992 Green Book on Entitlements.

Expenditures. Using data from National Association of State Budget Officers 1991 State Expenditure Report and 1990 population and income statistics from the Census Bureau, the program review committee compared Connecticut's AFDC expenditures with those of other states. In terms of total dollars devoted to AFDC in FY 90 (the last year actual expenditure data from all states were available), Connecticut ranked 13th of 49 states, with total expenditures of $305 million. However, on a per capita expenditure basis, Connecticut ranked 6th.

When AFDC expenditures are examined as a percentage of the total state budget, Connecticut ranked 10th, with 3.6 percent of its state budget going toward AFDC payments. As shown in the right hand column of Table III-2, this percentage was higher than the national average of 3.4 percent, and also higher than the nationwide median of 2.2 percent of states' budgets.

Caseloads and payments. Table III-2 also presents a variety of AFDC caseload and payment measures for Connecticut and the Northeastern states, as well as the national average and median. In terms of average monthly payments, Connecticut's benefits were the highest in the region. Connecticut's total AFDC expenditures, $347.2 million, rank fourth of the eight Northeast states, with the total being slightly lower than the national average of $375.7 million. But, if the median expenditure for all states -- $152.2 million -- is considered, Connecticut's total expenses were almost double that figure.

Table III-2. Comparison of Average Caseloads and Average Costs in the Northeastern States for FY 91.

	Average Monthly Caseload (000)	Recipiency Rate (% of Total Pop.)	Average Monthly Per-Case Payment	Average Number in Unit	Total AFDC Cash Expend. (Millions)	Percent of State's General Fund
CT	51.2	4.3	$565.	2.8	$347.2	3.6
NH	9.2	2.1	$410.	2.6	$45.3	2.9
NY	371.3	5.8	$552.	2.9	$2,460.8	4.3
MA	104.2	4.9	$533.	2.8	$666.5	4.3
ME	23.2	5.2	$407.	2.8	$113.2	4.1
VT	9.2	4.7	$495.	2.9	$54.6	4.4
NJ	118.1	4.7	$339.	2.9	$479.9	2.4
RI	19.4	5.4	$503.	2.8	$117.2	4.1
Median (all states)	39.1	4.0	$319.	2.9	$152.2	2.2
NTL. AVG.	80.7	5.0	$388.	2.9	$375.7	3.4

Sources: U.S. Congress. House Ways and Means Committee, 1992 Green Book, National Association of State Budget Officers, State Expenditures Report 1991.

Key for the following exhibits: FR=Federally Required; FO=Federal Option

Exhibit AFDC-1. AFDC Program: Federal Components Concerning Administration.	
States must have an approved state plan	FR
Uniform reporting requirements	FR
Provide benefits and services in integrated manner	FR
Implement appropriate measures to detect fraud	FR
Establish and administer an advanced data processing system for administering, controlling and accounting for eligibility	FO CT does operate a system
Determine eligibility within 45 days	FR
Redetermine eligibility at least annually	FR CT redetermines every 6 months
Must not impose stricter eligibility requirements than the federal government	FR
Develop a plan for preventing and reducing out-of-wedlock births, and offer referral and family planning services, but shall not require participation	FR

Exhibit AFDC-2. AFDC Coverage Groups.	
Dependent children under 18 and parent(s) or specified caregiver	FR
Dependent children and parents where principal earner is unemployed	FR (was FO prior to 1988) CT has covered since 1960s
Dependent children who are 18, if they are still in school and would reasonably be expected to finish by age 19	FO CT covers
Pregnant Women at 6,7,8, or 9 months	FO CT covers from 6 months
18-21 year-old full-time students in secondary or post-secondary education, if other criteria concerning AFDC are met.	No federal component or reimbursement. CT. had covered this group at 100% state funding from 1983 to 1991, when Public Act 91- 8 abolished the program

Exhibit AFDC-3. AFDC Eligibility Components	
Assets	Requirement Status
$1,000 Asset Limit, home excluded	FR
Lien on Property	FO CT Requires after 4 months
Car Valued at $1,500 or less	FR
If family has property assets, must make a good faith effort to sell them	FR
State requires that any transfer of assets within 24 months prior to application be made for fair market value and that the person be ineligible for as long as the value of the property would meet a reasonable standard of health and decency	The transfer of assets issue is not addressed at the Federal level. State law requires it.
Income	
Gross income must not exceed 185% of Standard of Need -- excluding the AFDC payment, Job Training Partnership Act (JTPA), earned income tax credit, and earned income of dependent children who are students for up to six months -- for the relevant family size	FR
Net income cannot exceed the Standard of Need for the unit size (certain types and amounts of income are required to be disregarded, while others may be disregarded -- SEE INCOME DISREGARDS BELOW)	FR
Not eligible if the parent is on strike	FR
Residency	
State cannot impose a durational residency requirement that denies eligibility to a unit where the child or the parent has resided at least one year before the application is made	FR CT has no durational residency requirement
States must require that either the dependent child or the caregiver relative is a citizen or a legal resident	FR

Living Arrangements	
States may require that a minor parent live with parents, guardian, or other adult (exceptions specified)	FO CT now requires through P.A. 92-211
States may also make the payment to the parents, guardian, or other adult	FO CT. now requires through P.A. 92-211
States cannot prohibit family from living with others outside the assistance unit, but states can consider that and prorate shelter and other expenses in determining benefit levels	FR regarding the prohibition, FO regarding the shelter allowance CT does not prorate
Exhibit AFDC-4. Additional requirements	
Must participate in the JOBS Program, if client meets certain criteria (full description of JOBS appears separately) and if state ensures childcare	FR, within state resources CT operates a program
Must assign child support rights to the state and cooperate in establishing paternity. If the recipient refuses or is uncooperative, the aid can be denied for that person, but not for the entire unit	FR
Exhibit AFDC-5. Monthly Income Disregards	
Maximum $175 per child in child care expenses ($200 if child is under 2)	FR
$90 per month working expenses	FR
$30 per month plus 1/3 of income for first 4 months working; then only $30 for next 8 months	FR
$50 in child support payments; the remainder goes to the state	FR
Certain income of parents of minor parent or stepparent	FR
States may take into account the value of other assistance (e.g., food stamps, rental subsidies, energy assistance)	FO CT does not take into account the value of other assistance in determining eligibility or amount of assistance

Exhibit AFDC-6. AFDC Benefit Level Requirements	
No federal requirements regarding minimum standard of need or minimum payment level (*See below)	CT. sets its payment at 100% of Standard of Need
*Federal requirements prohibit states from paying benefits below the levels of May 1988 or risk Medicaid reimbursements	FR
States must apply the needs standard and determine the benefits uniformly within the state	FR
States may also consider payment for a "special needs", either on a recurring or infrequent basis	FO CT. covers several special needs on a recurring basis (e.g., if rent is over 50% of basic benefit, add $50 to basic benefit)
Benefit payment must be at least $10 for unit to receive payment for that month	FR

AFDC-UNEMPLOYED PARENT (AFDC-UP)

Purpose: To provide cash assistance to two-parent families where the principal wage-earner is unemployed.

Statutory authority: C.G.S. Sections 17-85 and 17-86a (a) through (c), and Title IV-B of the Social Sceurity Act

Administering agency: Department of Income Maintenance

Federal requirement: Since 1988, the federal government has required that AFDC-participating states provide assistance through AFDC-UP. In Connecticut, the state has required the AFDC-UP program since 1961, although the provision was repealed in 1969, and then reestablished in 1975.

Federal options: The federal government allows those states that did not have a program prior to 1988 to establish a durational limit to AFDC-UP. For those states, like Connecticut, that had an AFDC-UP program prior to 1988, the durational limit is not an option.

Federal reimbursement: The federal government reimburses at least 50 percent of the benefit costs of the program, based on a formula including state per capita income. Connecticut is one of 12 states reimbursed at the minimal 50 percent rate.

Eligibility criteria: The eligibility criteria for AFDC-UP are the same as for the AFDC program. Applicants' incomes must not exceed 185 percent of the state's "standard of need", or $1,258 a month for a family of three. Also the family must show that its net income is lower than the state's payment levels, and that the assets of the family do not exceed established limits.

Establishing the benefit level: Similar to the overall AFDC program, the benefit levels for AFDC are established by each state through setting a standard of need, a dollar amount that would allow the unit to meet basic living expenses. Each state then decides what percentage of the standard of need it will pay. Connecticut is one of 17 states that sets payment at 100 percent of the standard of need.

Standard of need: The standard of need is based on the size of the assistance unit, and is the same under AFDC-UP as it is for the overall AFDC program. The components that comprise the standard of need are: rent; food; electricity; heat/hot water; fuel; clothing; personal items; and household supplies. In addition, in Connecticut, several other components considered special needs, are calculated into the overall standard of need and benefit level.

Eligibility criteria: In addition to the broad eligibility criteria that must be met for the AFDC program, applicants for AFDC-UP must also:

- be considered the principal earner in the unit and have worked for at least

30 days prior to receipt of aid, or still be working but less than 100 hours a month;

- not have refused an bona fide offer of employment or training;
- have worked 6 or more of the past 13 calendar quarters (and no more than 4 of those can be with the JPTA program) or received unemployment compensation (UC) or was qualified for UC;
- participate in the JOBS program within 30 days of aid receipt;
- participate in JOBS at least 16 hours a week; and
- apply for unemployment compensation if qualified.

Maximum benefit levels: The benefit levels for AFDC-UP are the same as those set for the regular AFDC program. The maximum benefit level for a family of three is:

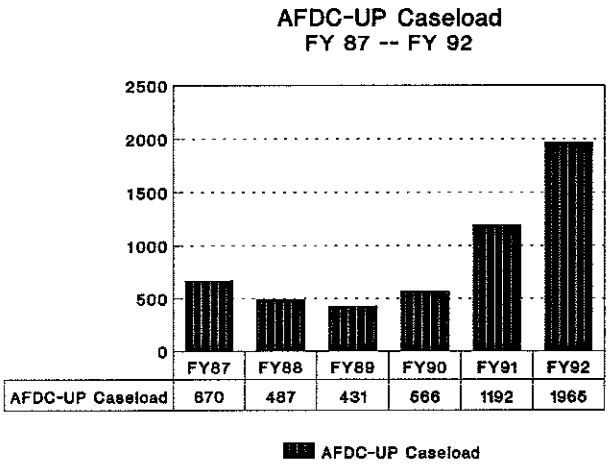
- $680 a month in Region A
- $581 a month in Region B
- $573 a month in Region C

Average benefits paid: The average benefit level for all cases in the AFDC-UP program for FY 92 was $665.41.

State caseload: The average monthly-caseload for FY 92 was 1,965 cases.

Expenditures: The total expenditures for the AFDC Unemployed Parent Program were $15,689,095 for FY 92.

Figure III-6.

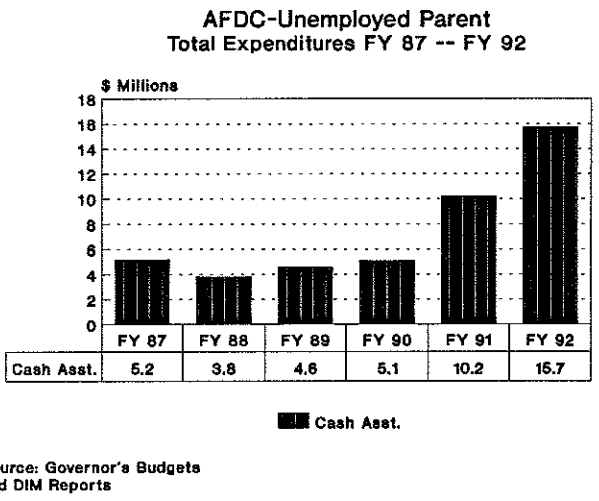


Source: DIM Public Assistance Reports

Trends in caseload and expenditures: The figures on the next three pages present trends in the AFDC-UP program. Figure III-6 shows the trend in the caseload from FY 87 to FY 92, and illustrates that the number of cases have increased by almost 200 percent over the five-year period. The number of cases in AFDC-UP actually fell in FY 88 and FY 89, before climbing again over the past three years. In fact, if the caseload increase is measured from its low point in FY 89 to its FY 92 levels, the increase is an astounding 355 percent.

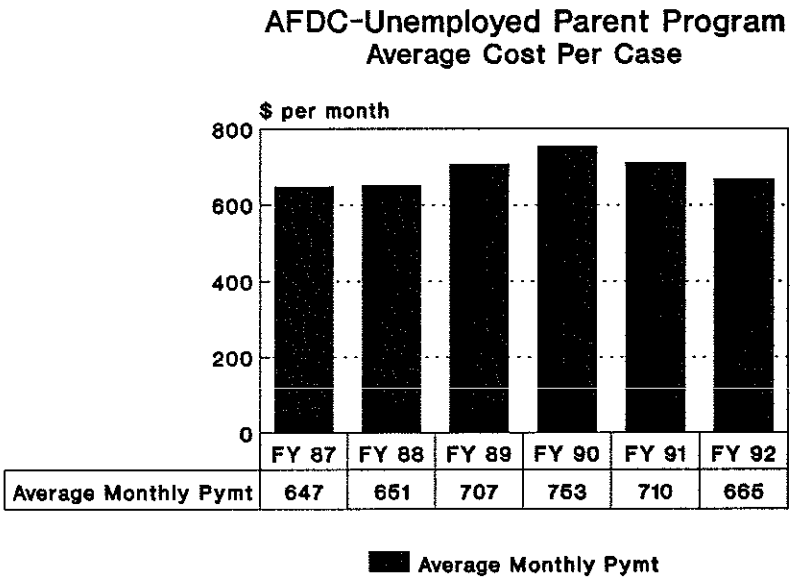
Figure III-7 shows the trend in overall cash expenditures for the same period. Similar to the caseload, the total expenses for the AFDC-UP program also swelled -- 300 percent over the period. While overall expenditures have climbed, the average cost per case in the program is about where it was in FY 87. As shown in Figure III-8, the average cost per case rose from $647 in FY 87 to $753 in FY 90, but has declined again to $665 in FY 92. Part of the explanation is the slight decrease in the number of persons in each case. Since each additional person increases the monthly benefit level about $100, a smaller unit size will translate into a lower monthly benefit. Also a factor is that there have been no benefit increases over the past two years to drive up the average cost per case. Another plausible reason is that since the passage of the Family Support Act of 1988, the federal government requires that persons employed under 100 hours a month also be eligible for benefits. This could have resulted in more persons that have some small incomes coming into the program, but dropping the average per-case cost.

Figure III-7.



Source: Governor's Budgets and DIM Reports

Figure III-8.



Source of Data: DIM Public Assistance Expenditures Report

JOB OPPORTUNITIES AND BASIC SKILLS (JOBS) TRAINING PROGRAM

Purpose: To operate a statewide employment and education program to assure that needy families with children obtain education, training and employment that will help them avoid long-term welfare dependence.

Statutority authority: Chapter 313 of the Connecticut General Statutes and Title IV-F of the Social Security Act

Administering agency: The JOBS program is operated by the Department of Income Maintenance. In Connecticut, this program is entitled Job Connection. The department conducts the assessment and case management functions, but does not provide any direct employment, training or educational services. Those services are either provided by other agencies, or DIM contracts for them.

Federal requirement: As part of the federal Family Support Act of 1988, states were required to establish a JOBS Program to the extent that state resources permit. Connecticut had a implemented a program for job training and education as an option prior to the 1988 federal legislation, but the Family Support Act made it mandatory for all states. Each state must submit a State Plan for JOBS indicating how it will operate the program.

The federal act specifies that certain AFDC recipients are required to participate, or risk losing a portion of their benefit. Those categories of recipients are outlined in Table III-3.

Federal reimbursement: The federal government reimburses the state for a certain percentage of its expenditures in the JOBS program. The percentage is based on a formula that includes: the state's expenditures under the previous job-training program (WIN); the state's share of adult AFDC population; the state's per capita income; and the type of expense. Connecticut is reimbursed 90, 60 or 50 percent, depending on the type of program costs. However, this program is considered a "capped entitlement," with an established federal annual appropriation for the program nationwide. Those amounts range from $600 million in FFY 89 to $1.3 billion in FFY 95, then levelling off to $1 billion annually in FFY 96 and thereafter.

State caseload: During FY 92 there were 7,151 persons actively participating in the JOBS program.

Program expenditures: Total General Fund expenditures for FY 92 were $5,568,724.

Required participation rate: Reimbursement for the program is based on the state meeting federally established participation rates of the AFDC population beginning with 7 percent of the population in FFY 90 and increasing to 20 percent in FFY 95. Somewhat higher participation rates are expected in the AFDC-Unemployed Parent program. States are also required to spend at least 55 percent of the JOBS program expenses on the targeted groups. These participation

rate requirements can be waived, if the state can demonstrate that it is making a good faith effort in achieving the goal, and if it has submitted a proposal for achieving it. In Connecticut, the participation rate, as indicated in the last available quarterly report (December 1991), was 27.6 percent, well above the required 11 percent for FFY 92.

Client participation requirements: Table III-3 outlines the program participation components, and whether they are federally required (FR) or a federal option (FO). Table III-4 outlines the components of the JOBS programs, including which elements states must offer and which are optional.

Table III-3. JOBS Program: Participation Requirements.	
All persons with children three years or older are required to participate	FR
States may require parents with children under age three, but no younger than one year, to participate	FO CT had required those with children age three or older to participate, but changed that via P.A. 92-211 to recipients with children age two or older
Provide child care to anyone who participates in the JOBS program[15]	FR
Provide payment or reimbursement for transportation, tuition, and other expenses necessary to participate in JOBS	FR
Participants cannot be required to participate in JOBS more than 20 hours a week if a child is under age 6	FR
Participants cannot be required to take a job offer that would result in a net loss in the family's cash income	FR

[15] A full explanation of the child care programs related to JOBS and other AFDC components is contained in a separate program description.

Table III-4. Components of the JOBS Program	
Federally Required	Federal Option (but State Must Provide 2 of 4 Components)
Education: must include high school or equivalency; basic and remedial education; and English to speakers of other languages (ESOL) program	Group and Individual Job Search*
Job Skills Training	On-the-Job Training*
Job Readiness Training	Work Supplementation
Job Development and Placement	Community Work Experience
	* Connecticut provides

Both federal and state laws require that certain AFDC recipient groups be targeted for the JOBS program as follows:

- AFDC recipients who have been receiving assistance for 36 of the preceding 60 months;
- custodial parents under age 24 who have not completed high school or who have limited or no work experience in the previous year; and
- individuals who are members of an AFDC family in which the youngest child is within two years of being ineligible because of age.

However, since Connecticut has been unable to serve all mandated populations, DIM has its AFDC clientele into categories for priorities for service as outlined below:

- particpants recruited through DIM programs contractors;
- young parents;
- targeted clients age 20 and over who wish to participate; and
- other mandatory target groups.

Caseload and Expenditure Trends:

Caseload. Because of changes in the federal requirements of the program, changes in the state administration of the program, and problems with the accuracy of the data, long-term caseload trends in the JOBS program are not available. The JOB Connection quarterly reports contain information on caseloads, and this is presented in Table III-5. The table indicates the numbers of participants who are active in the program at the end of that particular quarter, although they might have entered the program at any time prior to that date. The quarters reported are different because DIM has not consistently issued reports for the JOBS program. As the table shows, the number of recipients who have become employed has remained fairly steady at slightly above 2,000. However, the participants enrolled in the education and training category have increased by more than 2,300 participants (over 40%) in the 20-month period.

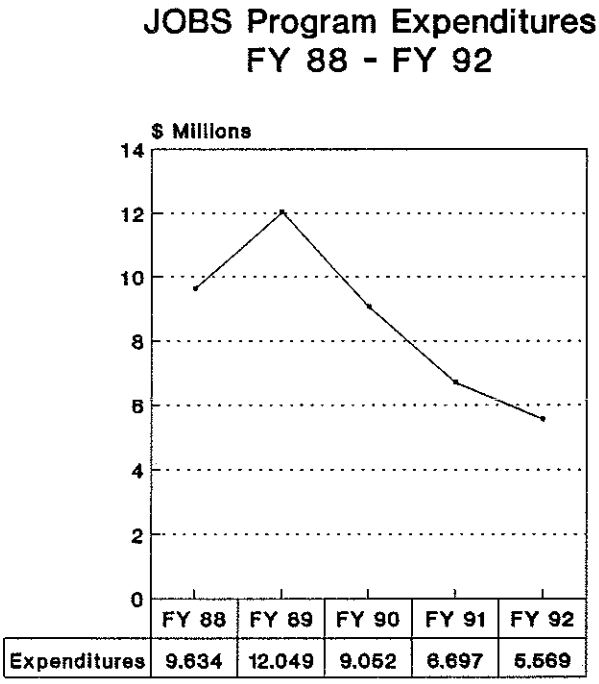
Table III-5. Program Activity For Three Selected Quarters: FY 90 -- FY 92.

JOBS Category	April 1990	June 1991	December 1991
Employed as a result of JOBS, but still receiving AFDC	2,119	2,012	2,057
Education and Training	5,051	6,928	7,403
Total	7,170	8,940	9,460

Source of Data: DIM, Job Connection Quarterly Reports

Expenditures: The expenditures for the JOBS program for fiscal years 1988 through 1992 are presented in Figure III-9. In FY 88, JOBS expenditures were about $9.6 million, but jumped the following year to slightly over $12 million, a 24 percent increase. Since then, because of state fiscal constraints, program spending has declined each year to about $5.6 million for FY 92.

FIGURE III-9.



CHILD CARE ASSISTANCE FOR AFDC CLIENTS

Purpose: To provide certain families on AFDC with reimbursements for their child care expenses.

Administering agency: Department of Income Maintenance

Statutory authority: C.G.S. Section 17-486, and Title IV-A and IV-F of the Social Security Act.

Federal requirement: Each state must guarantee child care for its AFDC families who need child care in order for the recipient to participate in the JOBS program or for employment. The federal government allows the states options concerning how it will be provided. The state may actually provide the day care, contract for the services, issue vouchers, or provide reimbursement for the services. Connecticut provides reimbursement to the recipients.

Federal reimbursement: The federal government reimburses the states from 50 to 80 percent, depending on the state's per capita income. Connecticut receives 50 percent reimbursement. There is no federal cap on the total expenses for this nationwide as there is for other expenses related to the JOBS program.

Eligibility criteria: The applicant must be:

- an AFDC recipient who is working and needs child care;
- an AFDC recipient who needs child care to participate in the JOBS program;
- an AFDC recipient who needs child care in order to accept employment; or
- a person who is no longer eligible for AFDC cash assistance because of income from employment is eligible for transitional child care.

Benefit levels: The child care assistance benefits are a reimbursement to the recipient of: the actual day care charges; the market rate; or $325 per month per child; whichever is lowest.

State caseload: The number of cases receiving child care assistance for FY 92 was 3,158. The breakdown of the caseload for FY 92 by eligible category was:

- 2,100 for JOBS participants;
- 425 for AFDC working recipients; and
- 634 for AFDC transitional child care.

Total expenditures: For FY 92 the total expenditure for child care services was $12,595,228.

Average payment: The average monthly cost per case for FY 92 was $332.32

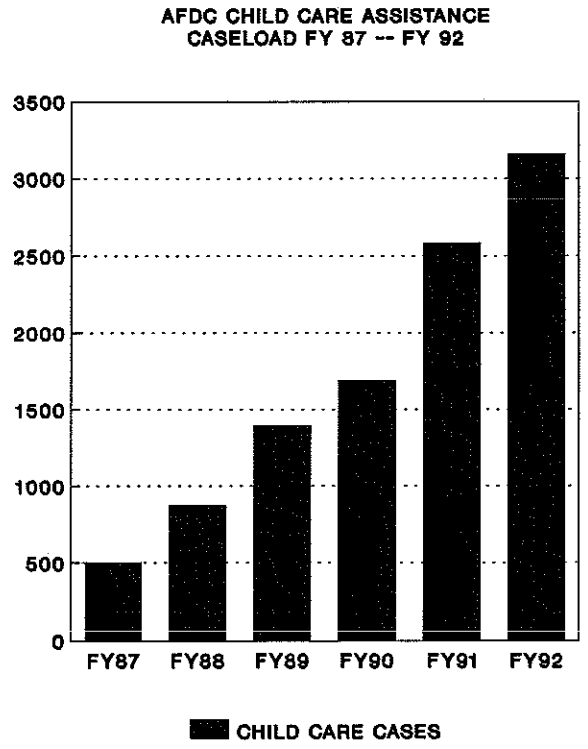
Durational limits: There are no durational limits for those AFDC recipients who are working or participating in JOBS, but there is a 12-month limit for those who are no longer receiving cash assistance. These child care recipients must also pay part of the costs for child care, depending on their income.

Program history: Prior to the federal Family Support Act of 1988, which established the current federal requirements concerning child care provisions, the federal government required child care services be provided for some AFDC clients, but for fewer groups, for shorter durations, and for lesser amounts.

Caseload and Expenditure Trends:

Caseload: The number of child care service cases has grown from 501 cases in FY 87 to 3,158 in FY 92, an increase of more than 500 percent. The average annual increase has been about 46 percent. Figure III-10 shows the total caseload for each of the six years.

FIGURE III-10.



Source of Data: DIM Public Assistance Expenditure Reports

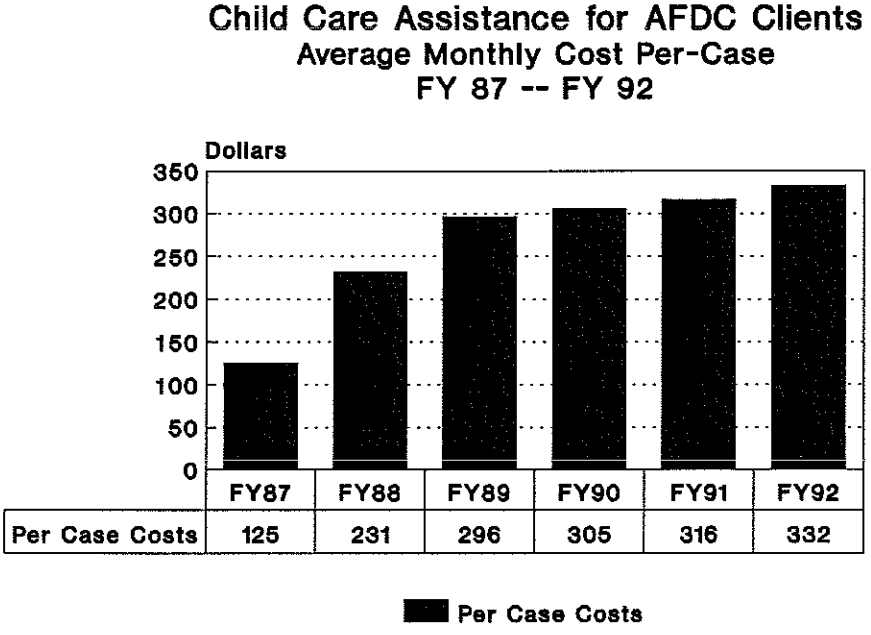
Expenditures: The expenditures for child care services for AFDC recipients increased more than twelve-fold over the FY 87 to FY 92 period. Table III-6 shows the annual expenditures for each of those six years. As already noted, the caseload in the program has also grown dramatically, contributing substantially to the overall costs. But as shown in Figure III-11, the average monthly cost per case has also risen sharply -- from $125 a month in FY 87 to

$332 a month in FY 92 -- and translates to a percentage increase in monthly costs of 206 percent. The rising average monthly costs multiplied by the growth in caseload generate the dramatic increase in program expenditures.

Table III-6. Child Care Assistance for AFDC Recipients, Expenditures For FY 87 -- FY 92.

Year	Total Expenditures	Percent Change
FY 87	$753,345	--
FY 88	$2,419,848	221%
FY 89	$4,939,896	104%
FY 90	$6,166,730	26%
FY 91	$9,814,451	59%
FY 92	$12,595,228	28%

FIGURE III-11.



DIM Public Assistance Expenditure Reports

STATE SUPPLEMENT PROGRAM

Program Purpose: The State Supplement program, also known as Aid to the Aged, Blind and Disabled (AABD), provides payments to aged, blind, and disabled people who qualify, or would qualify except for income, for federal Supplemental Security Income, Social Security, Veteran's Benefits, private pensions, or income from other sources. The objective of the program is to enable poor elderly, blind, or disabled individuals to support themselves by furnishing them with financial assistance. (See Exhibit SS-1 for a listing of federal SSI, and mandatory and optional State Supplement recipients.)

Administering agency: State Department of Income Maintenance.

Statutory authority: Title XVI of Social Security Act, and C.G.S. Sections 17-2, 17-109 through 17-109a, 17-116, and 17-124.

Federal requirements: There are three major requirements regarding the State Supplement program:

- Mandatory recipients: Mandatory coverage for persons receiving assistance for old age, blindness, or disability prior to 1974 passage of Title XVI of Social Security Act.

- Absolute floor: The absolute minimum benefit a state may pay its optional State Supplement recipients, and comply with federal pass-through requirements, is the benefit it was paying in March 1983.

- "Maintenance of Effort" (MOE): States must maintain expenditure levels for their State Supplement programs at levels equal to or above expenditures made during the previous calendar year. Failure to comply with this regulation jeopardizes a state's federal Medicaid reimbursement for all Medicaid recipients. A state that fails to comply with the maintenance of effort provision has a one-year grace period to meet the requirement.

The maintenance of effort provision can be met through maintaining individual benefit levels ("pass-through provision") or by using the total expenditure method. States are allowed to change methods for complying with the provision. The first payment method requires that benefits not be reduced when there is an increase in federal benefits. The second method requires the state to spend as much in any calendar year on the State Supplement program as it did during the previous calendar year. Connecticut is currently using the second method to comply with the maintenance of effort provision.

Federal reimbursement: None. The State Supplement program is totally state-supported and administered with money from the General Fund.

Federal options: The federal government has options that states may elect when operating their State Supplement programs. The options affect benefit levels, liens, program expenditures, and residency requirements. (See Exhibit SS-2.)

Eligible recipients: all applicants and recipients must meet income and asset requirements and are:

- over 65 years;
- disabled and between aged 18 to 65 years; or
- blind persons.

Ineligible recipients:

- Any person who is in a medical facility and receiving Medicaid payments at a level exceeding 50 percent of the cost of the person's care;
- Any person who resides outside the United States;
- Any recipient of assistance under the Aid to Families with Dependent Children program;
- Inmates of public institutions who are ineligible for federal benefits under the Medicaid program;
- Any person who refuses treatment for alcoholism or drug addiction; and
- Any blind or disabled person who refuses vocational rehabilitation.

State caseload: FY 92 caseloads:

•	Aged:	9,242 clients
•	Blind:	160 clients
•	Disabled:	18,376 clients
•	**Total:**	27,778 clients

Average cost per case: FY 92 average monthly benefit:

•	Aged:	$262.20
•	Blind:	$264.50
•	Disabled:	$326.75

Total expenditures: FY 92:

- Aged: $29,079,620
- Blind: 506,254
- Disabled: $72,052,230

- **Total:** $101,638,104

Broad eligibility criteria: Aged, blind, or disabled applicants and recipients must be receiving, or be qualified to receive except for income, assistance from federal Supplemental Security Income, Social Security, Veteran's Benefits, or another source, and must meet income and asset eligibility criteria. (See Exhibits SS-3 and SS-4.)

Eligibility for other programs: Categorical eligibility for Medicaid and Food Stamps. Recipients must qualify for energy assistance.

Program Description

Administration: Payments are issued directly to eligible recipients by DIM. Each state has the option of operating its State Supplement program or allowing the federal government to administer the program, but only if the State Supplement eligibility criteria are the same as SSI criteria. This is done by combining federal SSI payments with the State Supplement payments.

Benefits: States are allowed to set a limit of 300 percent of the federal SSI benefit as the maximum allowable income for a State Supplement applicant or recipient. State Supplement benefits are calculated by deducting a recipient's monthly earned and unearned income, minus certain income disregards, from a monthly need amount. The maximum monthly benefit an individual may receive is $325, while the maximum monthly benefit for a couple is $461. This amount is set by DIM.

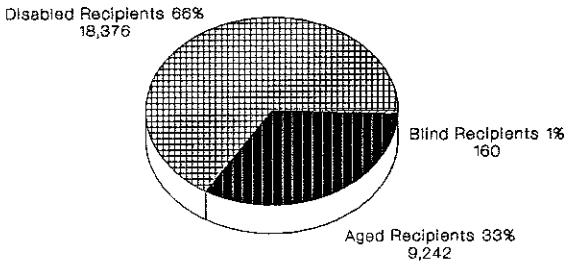
State Supplement recipients who become institutionalized and receive support from Medicaid while residing in a licensed long-term care facility become ineligible for State Supplement benefits, but are eligible for a monthly personal needs allowance of $30 per month from SSI.

Federal guidelines: Federal laws and regulations require that certain incomes and assets of ineligible individuals residing in an applicant's or recipient's household must be considered or "deemed", when determining State Supplement eligibility. The laws and regulations also address which incomes and assets of ineligible individuals in the applicant's household must be excluded or deemed. (See Exhibits SS-5 and SS-6.)

Caseload and caseload trends: The total number of State Supplement recipients for FY 92 was 27,778 people. As Figure III-12 shows, the percentage breakdown for the State Supplement population was: disabled - 66 percent, aged - 33 percent, and blind - 1 percent.

Figure III-12.

State Supplement Population
Categorical Breakdowns: FY 92



Source: Department of Income Maintenance

Table III-7 lists the numbers of State Supplement recipients for the last five fiscal years and the percentage increase from the previous year in the total population. The average annual growth in population had been 14 percent until FY 92, when the population increased by 2.1 percent from the previous fiscal year.

Table III-7. State Supplement Program Recipients by Category (FY 88 - FY 92).

Category	FY 88	FY 89	FY 90	FY 91	FY 92
Aged	7,164	7,793	8,253	9,032	9,242
Blind	119	137	143	154	160
Disabled	12,300	14,198	15,770	18,023	18,376
Total (% Increase)	19,583 (+21.1%)	22,128 (+13%)	24,166 (+9.2%)	27,209 (+12.6%)	27,778 (+2.1%)

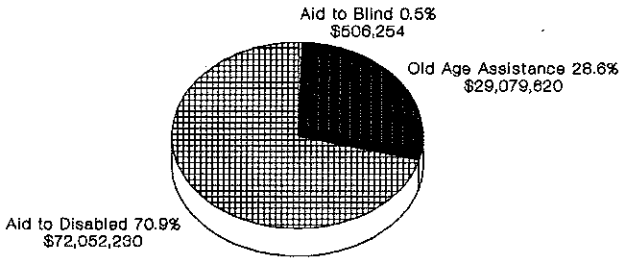
Source: Office of Fiscal Analysis

Expenditures and expenditure trends: The total expenditure for Connecticut's State Supplement program for FY 92 was $101,638,104. As Figure III-13 shows, payments to disabled recipients comprised 70.9 percent of the State Supplement budget, while aged recipients received 28.6 percent and blind recipients received 0.5 percent of the total payments. The program budget increased by an average of 23 percent per year until FY 92 when program expenditures fell 5.9 percent from the previous fiscal year.

Table III-8 lists the program expenditures from FY 88 to FY 92, along with the percentage growth from the previous year for each year's total budget.

Figure III-13.

State Supplement Budget: FY 92



Source: Department of Income Maintenance

Table III-8. Connecticut State Supplement Expenditures (FY 88 - FY 92).

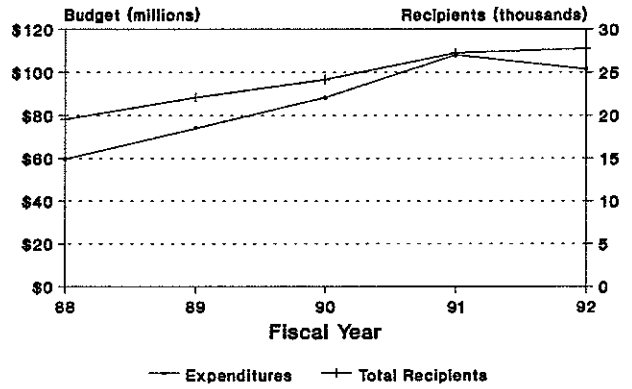
Program	FY 88	FY 89	FY 90	FY 91	FY 92
Old Age Assistance	$19,873,926	$22,359,049	$25,451,596	$31,258,134	$29,079,620
Aid to Blind	$324,508	$423,310	$468,335	$567,983	$506,254
Aid to Disabled	$39,469,531	$51,338,063	$62,387,571	$76,214,403	$72,052,230
Total (% Increase)	$59,667,965 (+26.5%)	$74,120,422 (+24%)	$88,307,502 (+19%)	$108,040,520 (+22.2%)	$101,638,104 (-5.9%)

Source: Governor's Budgets, DIM.

Budget and population. Figure III-14 shows the growth in the State Supplement budget and population for the past five fiscal years. Population growth tracked budget growth during all fiscal years. The growth rate for both categories slowed for all fiscal years. The State Supplement budget grew at a faster rate than the recipient population by an average of 9 percent per year until FY 92 when the population growth exceeded expenditure growth by 8 percent. The declines in expenditures and population growth were the result of the following FY 91 cost-reducing measures: 1) reduction of the income disregards for applicants and recipients, 2) no cost-of-living increase for recipients, and 3) a constrained increase in boarding home rates.

Figure III-14.

State Supplement: Annual Growth in Expenditures and Recipients

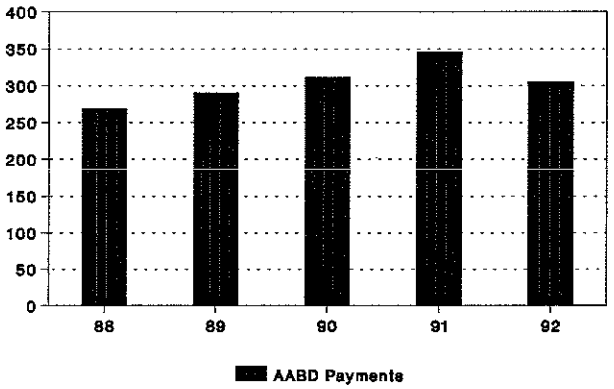


Source: Governor's Budgets

Monthly benefits: Figure III-15 shows the annual growth in the average monthly State Supplement benefit for Connecticut recipients. The average monthly benefit was increasing at an average annual rate of 9 percent until FY 92 when the average benefit decreased by 12 percent from the previous year.

Figure III-15.

Average Monthly State Supplement Benefit
FY 88 - FY 92



Source: Governor's Budgets, OFA

Comparisons with Other States

Population: Table III-9 lists the number of aged, blind, and disabled State Supplement recipients and total recipients for the Northeastern states, and the recipiency rate per state as a percentage of overall state population. State populations, as measured by the 1990 Census, are listed below each state. Connecticut had the fourth highest number of total State Supplement recipients for the northeastern states. The table also reveals that Connecticut had the second lowest percentage of overall population receiving State Supplement benefits, with less than 1 percent of its total population enrolled in the program.

Table III-9. Northeastern State Supplement Recipients (June 1991).

State (Population)	Aged	Blind	Disabled	Total	Recipiency Rate
Connecticut (3,287,116)	9,145	161	17,572	26,878	0.82
Massachusetts (6,016,425)	30,876	3,228	64,683	98,787	1.64
Maine (1,227,928)	4,719	246	15,255	20,220	1.65
New Hampshire (1,109,252)	1,421	191	3,431	5,043	0.45
Vermont (562,758)	1,733	112	6,899	8,746	1.55
Rhode Island (1,003,464)	3,735	197	11,314	15,246	1.52
New York (17,990,455)	102,138	3,755	276,803	382,696	2.13
New Jersey (7,730,188)	27,973	1,123	71,402	100,498	1.30

Source: Social Security Bulletin, Volume 54, No. 12, December 1991; Census Bureau, Report CB 91-07, January 1991.

State expenditures: Table III-10 compares Northeastern State Supplement programs, including how they are administered, the total expenditure, and that state's rank nationwide for expenditures and recipients. Connecticut and New Hampshire administer their State Supplement programs as they are "209(b)" Medicaid states and have different eligibility criteria from the SSI program. Connecticut's Medicaid status allows it to impose more stringent income and asset criteria for determining Medicaid eligibility, but it cannot have criteria that are more stringent than the criteria it was using on January 1, 1972. The state currently ranks third among Northeastern states and fifth nationwide for State Supplement budget expenditures and fourth among Northeastern states and twelfth nationwide for recipients.

Table III-10. Northeastern State Supplement Program Expenditures - FY 91.

State	Administration	Total Expenditures	Rank-U.S.: Total Expenditures	Rank - U.S.: Total Recipients
Connecticut	State	$98,838,000	5th	12th
Massachusetts	Federal	$124,761,000	3rd	6th
Maine	Federal	$7,731,000	16th	13th
Rhode Island	Federal	$12,973,000	19th	18th
New Hampshire	State	$7,765,000	15th	27th
Vermont	Federal	$9,374,000	13th	23rd
New York	Federal	$410,081,000	2nd	2nd
New Jersey	Federal	$57,328,000	10th	5th

Source: U.S. House of Representatives, Ways and Means Committee, 1992 Green Book.

Exhibit SS-1. Federal Supplemental Security Income and State Supplement Programs: Eligible Recipients

Federal Supplemental Security Income Recipients	Mandatory State Supplemental Recipients	Connecticut State Supplement Recipients
• Aged individuals: 65 years or older who meet income criteria. • Blind individuals: 20/200 vision or less with use of correcting lens in better eye, or those with tunnel vision of 20 degrees or less. • Disabled individuals: unable to engage in any substantial gainful activity by reason of a medically determined physical or mental impairment expected to result in death, or that has lasted, or can be expected to last for a continuous period of at least 12 months. • Children: less than 18 years with an impairment of comparable severity with that of an adult may be considered disabled. • A recipient must be a U.S. citizen, or legal immigrant admitted for permanent residence, and residing in the United States or Northern Mariana Islands.	• Aged, blind or disabled individuals who were receiving benefits for old age, blindness or disability prior to 1974.* * As of March, 1991, there were only 3,790 mandatory recipients of state supplementation nationwide, or less than 0.1 percent of all state supplement recipients. According to DIM, there are no mandatory recipients in Connecticut.	• Aged, blind or disabled individuals who receive a low monthly SSI or Social Security benefit, private pension, Veteran's benefit, or a limited income from another source. • Blind applicants must be certified as blind by the Social Security Administration or the State Board of Education Services for the Blind (BESB). • Blindness is defined as 20/200 or less with correcting lens in better eye, or those with tunnel vision of 20 degrees or less. • Disabled applicants must be between the ages of 18 and 65 and certified as disabled by the SSA. • Persons who may not otherwise be eligible may receive assistance to cover the costs of room, board, and personal needs if they reside in a licensed boarding home. • Recipient must be a permanent state resident or demonstrate the intent to become a permanent resident.

Exhibit SS-2. Federal Options for the State Supplement Program.

State Supplement Options	Connecticut State Supplement Program*
• State may have federal government administer its State Suppelment program, but only if federal SSI and State Supplement eligibility criteria are the same.	• State does not differentiate payments to aged, blind or disabled recipients based on their category.
• State may vary payment levels for each category of state supplement recipient.	• State does not vary payments on a regional basis.
• State may have two payment regions based on regional cost-of-living differences.	• State allows unlimited living arrangements for both singles and couples.
• State may permit up to five variations in living arrangements.	• State residency requirement: applicant or recipient must be a permanent state resident or demonstrate the intent to become a permanent resident.
• State may have a durational residency requirement.	• State places a lien against an individual's property for the amount of assistance received.
• State may place a lien against a recipient's property provided the lien is consistent with SSI program guidelines.	• State currently employs the total expenditure method for complying with the maintenance of effort provision.
• State may meet the "maintenance of effort" requirement by maintaining total program expenditures at or above the previous calendar year's level, or by not reducing payments to recipients who receive an increase in federal benefits. Failure to meet the MOE requirement jeopardizes a state's federal Medicaid reimbursements.	* Connecticut State Supplement program is state-administered since its eligibility criteria for State Supplement are different from the SSI program.
• State may terminate its program, but will jeopardize its federal Medicaid reimbursements if it takes such action.	

Exhibit SS-3. Federal Supplemental Security Income And State Supplement Programs: Income Guidelines.

Supplemental Security Income Program	State Supplement Program
Maximum Allowable Income	**Maximum Allowable Income**
To receive SSI, the following income limits apply to individuals and couples: • **Individual**: $442 per month if paid only unearned income, $929 per month if receiving wage income. • **Couple**: $653 per month if paid only unearned income, $1,351 per month if receiving wage income.	To receive State Supplement, income for individuals and couples may not exceed: • **Individual**: $1,266* per month. • **Couple**: $1,899* per month. * (300 percent rule): Individuals and couples are allowed to have a maximum income of 300 percent of the Federal SSI benefit.
Income Disregards	**Income Disregards**
• $20 of monthly income from most sources is excluded from countable income. • In addition, the first $65 of monthly earned income plus one-half of remaining earnings. • Blind and disabled recipients may also have income and resources disregarded under a plan to acheive self-support. • Work-related expenses are disregarded for blind applicants or recipients, while impairment-related expenses are disregarded for disabled applicants or recipients. • In-kind (noncash) assistance is counted as income unless specifically excluded by statute.	• $183 per month of any unearned income (SSI, Social Security, private pension, etc.). • $250.90 per month for individuals with at least one roommate. • $90.70 per month for an individual residing in a boarding home. • Additional disregards: 1) if aged or disabled, $65 per month of earnings; if blind, $85 per month; and 2) one-half of remaining earned income; and 3) allowable work expenses, if impairment related. • There are additional disregards for self-employment and personal expenses, and self-support plans for blind and disabled recipients. • The value of in-kind (noncash) assistance received by the recipient.

Exhibit SS-4. Federal Supplemental Security Income and State Supplement Asset Guidelines	
Federal Supplemental Security Income	Connecticut State Supplement
Maximum Allowable Assets	Maximum Allowable Assets
• **Individual**: Assets may not exceed $2,000 in value. • **Couple**: Assets may not exceed $3,000 in value.	• **Individual**: Assets may not exceed $1,600 in value. • **Couple**: Assets may not exceed $2,400 in value.
Asset Exclusions	Asset Exclusions
• A home is not counted as an asset regardless of its value, unless it produces income. • A lien for the value of the aid that is given will be placed on a recipient's home, but will not be collected while the recipient is living in the home. • Household goods and effects worth up to $2,000 are excluded. • Certain personal items and medical equipment are exempted without limitation. • The value of business property is excluded up to $6,000, if the business is essential to a person's self-support.	• Real property used as a principal residence by a recipient or applicant is excluded when determining eligibility, but a lien is placed against a recipient's home. • All essential household items are excluded. • All personal effects are excluded. • One motor vehicle is totally excluded if the recipient or his/her spouse needs the vehicle for employment, transportation for medical treatment, or the vehicle has been modified for operating by or transporting a handicapped person.

Asset Exclusions (Contd.)	Asset Exclusions (Contd.)
• The total value of property granted by a governmental agency is excluded if it is being used to produce income. • The resources of a blind or disabled person which are necessary to follow an approved plan for achieving self-support are wholly excluded. • The entire value of one automobile is excluded if it is necessary for employment, transportation to receive medical treatment, is modified to be operated by a handicapped person, or to provide transportation to perform essential daily activities. • If no automobile can be excluded using the above provisions, then the value of one vehicle may be excluded up to $4,500. • Income producing property is excluded up to $6,000 if it produces goods necessary for daily activities. • The face value of life insurance, up to $1,500 is excluded.	• If no motor vehicle is excluded using the above criteria, then the fair market value of a recipient's vehicle up to $4,500 is excluded. • The cash surrender value of a recipient's life insurance policy is excluded up to $1,500. • Burial contracts up to $1,200 are excluded.

Exhibit SS-5. Federal Supplemental Security Income and State Supplement Guidelines: Deemed Assets

Supplemental Security Income	Connecticut State Supplement
Income and assets of: • Ineligible spouse and any ineligible children under age 21 in the household. • Natural or adoptive parent or stepparent living in the same household of a child under age 18. • Sponsor (and the sponsor's spouse) to an alien for 3 years after the alien is admitted for permanent residence. • Deeming (or consideration of income and assets) occurs whether or not the alien lives in the sponsor's household. • A person living in the same household as a qualified eligible individual if the person is essential for the care of the recipient.	Income and assets of: o an eligible individual's spouse when they are considered to be living together. o Parents living with children under age 18 who apply for, or receive Medicaid on the basis of blindness. • A non-resident spouse of an institutionalized Medicaid recipient who was receiving state supplement payments. • A non-citizen's sponsor and sponsor's spouse (if living with the sponsor), for a period of three years. • If the sponsor is sponsoring two or more non-citizens, the assets of the sponsor are divided equally among the sponsored non-citizens.

• = Federal Requirement; o = State Requirement

Supplemental Security Income (contd.)	Connecticut State Supplement (contd.)
Exceptions: • None of the exclusions from income which apply to an ineligible spouse or parent apply to an essential person except those exclusions provided by federal laws other than the Social Security Act. • No deeming of a stepparent's income or assets if the child lives in the same household due to the death, divorce, or separation of the natural parent. • The essential person's income and resources may be disregarded in calculating the SSI payment if the amount deemed would make a qualified individual ineligible, or if the qualified individual so chooses.	Exceptions: o Parents who live apart from their children. o Spouses who live apart. o Spouses who reside in different rooms in the same boarding home. o Nonresident spouses of institutionalized Medicaid recipients will not have their assets deemed after the initial month the institutionalized spouse is eligible to receive Medicaid payments.

Exhibit SS-6. Federal Supplemental Security Income and State Supplement: Deeming Exclusions

Supplemental Security Income	Connecticut State Supplement
• Income excluded by federal laws other than the Social Security Act.	• The value of coupon allotments made under the Food Stamp program.
• Public income-maintenance payments received by an ineligible spouse or parent.	o Cash contributions from agencies and organizations for goods or services not in the department's standards of needs.
• Any income used in calculating the amount of income-maintenance payments.	o The value of goods and services given as in-kind income except when provided by General Assistance.
• Income of an ineligible spouse or parent used by a public income-maintenance program to determine the amount of that program's benefit to someone else.	o Gifts received too irregularly or infrequently to be counted, but not more than $30 per calendar quarter.
• Any portion of a grant, scholarship or fellowship used to pay tuition or fees.	• Payments made under means-tested energy assistance programs.
• Money received for providing foster care to an ineligible child.	o Reimbursements for expenditures that do not represent benefit or gain to the recipients.
• The value of food stamps and Department of Agriculture donated foods.	o Money received for the care and support of a person who is not a state supplement recipient.
• Tax refunds on income, real property, or food purchased by the family.	o Security deposits returned to a recipient by a landlord.

• = Federal Requirement; o = State Requirement

Supplemental Security (contd.)	State Supplement (contd.)
• Income used to fulfill an approved plan for achieving self-support (blind and disabled individuals). • Income used to comply with the terms of court-ordered support, or child support payments enforced under Title IV of the Social Security Act. • The value of in-kind support and maintenance. • Periodic payments made by a state under a program established before July 1, 1973, and based solely on duration of residence and attainment of age 65. • Disaster assistance. • Certain home energy and support maintenance assistance. • Income received infrequently or irregularly. • Work expenses if the ineligible spouse or parent is blind. • Income of an ineligible spouse or parent which was paid under a federal, state or local governmental program to provide chore, attendant, or homemaker services.	• HUD, Section 8, rent and utility subsidies. o Rent money returned to a recipient by a court. o State funded assistance payments which are based on need if the recipient's income is used to establish the payment amounts. • Earned Income Tax Credits received as advance payments or as a single non-recurring payment. • Payments received by recipients and applicants from Housing and Urban Development (HUD) Community Block Grant Funds. • Benefits received under Title VII, Nutrition Program for the Elderly, of the 1965 Older Americans Act. o Payments made by the Department of Human Resources for the expenses of day care and essential services unless the recipient is the provider of the services. o Security deposits paid by DIM.

MEDICAID

Program purpose: Medicaid is a means-tested entitlement program that pays for medical services for certain low-income persons. Medicaid does not provide medical assistance for all poor persons, only for those that are in one of the groups designated under Title XIX. Actual payment for services is made directly to medical vendors.

Administering agency: State Department of Income Maintenance

Statutory authority: Title XIX of the Federal Social Security Act, and C.G.S. Sections 17-12q through 17-12s, and 17-134a through 17-134ff

Federal requirements: State participation in Medicaid is entirely optional, but if a state does participate, it is required to provide certain medical services to specific groups of individuals. States have the option of extending coverage to additional groups of individuals and providing a wider array of optional services.

Federal reimbursement: States are reimbursed based on a variable matching formula that is inversely related to a state's per capita income and is annually adjusted. Statistical factors used in the formula are state medical assistance expenditures and per capita income. The minimum federal matching share is 50 percent, which is the level of reimbursement in Connecticut.

Program recipients: In general, low-income children, pregnant women, adults with children, elderly, blind, and disabled persons, who meet income and asset requirements are eligible to become Medicaid recipients. Medically needy persons who, except for income and assets, would be automatically eligible for coverage, may be eligible for Medicaid, if their income falls below a set level after medical expenses are paid.

Program description: Within federal guidelines, each state designs and administers its own Medicaid program. Because of this, wide variation occurs among states in terms of persons covered, type and scope of medical benefits offered, and amounts of payments for services.

The state issues a Medicaid card to all eligible recipients to use when they need to see a medical provider. Since not all eligible recipients will have to receive medical treatment, the number of eligible recipients and those actually using services can vary widely.

State caseload: eligible recipients (monthly average) FY 91 - 234,462
recipients served (monthly average) FY 91 - 163,095

Average cost per recipient served: $810.00 (monthly average) - FY 91.

Eligibility criteria: To receive Medicaid, an individual must qualify as a member of a specific group (such as low-income pregnant women or young children) and meet the specific income

and asset limits set for that group. In most cases, income and asset limits are set by the state within broader federal guidelines.

There are a total of 54 Medicaid coverage groups, each having varying income and resource requirements to be eligible for coverage. Figure III-16 shows a general diagram of the types of federally required and optional Medicaid coverage groups, as well as the different mix of services that may be provided to each group. Federal law requires states to provide a comprehensive array of services to the categorically needy. Conversely, services that are mandated by the federal government for the medically needy are much less thorough.

The coverage groups are divided into two broad groups: categorically needy and medically needy. The categorically needy group is subdivided into 26 mandatory and 17 optional coverage groups. The medically needy contains 11 coverage groups. A short description of the difference between the coverage groups follows.

Categorically Needy

Mandatory categorically needy: If a state operates a Medicaid program, the federal government requires that coverage must be extended to those individuals who qualify as a member of any of the 26 separate coverage groups under this classification. This category includes most individuals who receive federally assisted income-maintenance payments, as well as related groups not receiving cash payments. Medicaid coverage is mandated for:

- persons who receive AFDC, or are AFDC-related but not receiving AFDC;
- recipients of Supplemental Security Income (SSI); were eligible for Medicaid prior to SSI implementation; or would qualify for SSI except the state has imposed more restrictive requirements (209(b) state); and
- low-income pregnant women and children who meet specific income and asset limits.

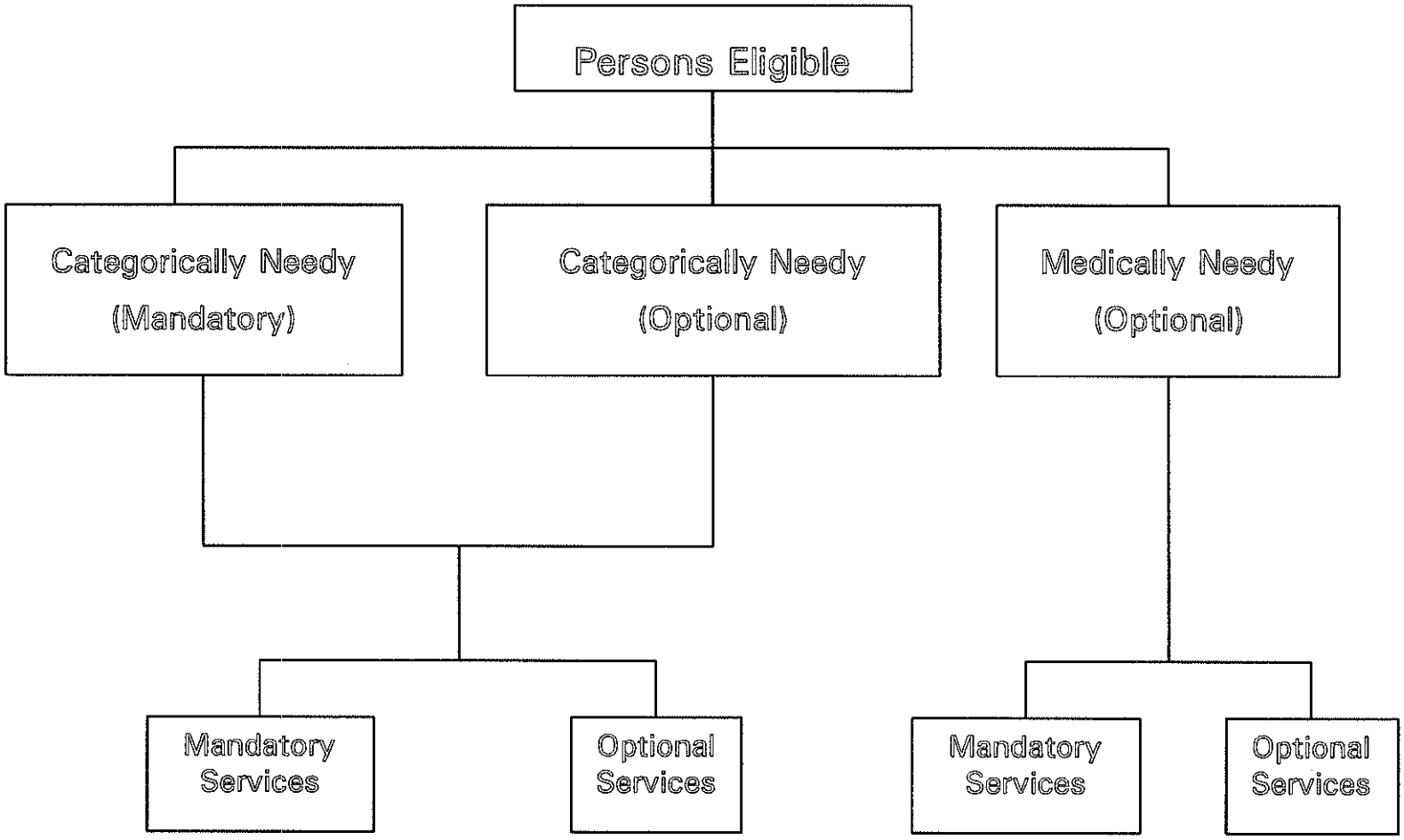
Exhibit MED-1 on page 72 shows the coverage groups that are both required and optional under Medicaid law. In Connecticut, as in all Medicaid participating states, all groups shown in the first column receive Medicaid. In the second column, all federally optional groups are shown; however, those that Connecticut has extended coverage to are in bold highlight. Those groups not in bold highlight are not covered in Connecticut.

Optional categorically needy: There are 17 separate coverage groups under this subcategory and provision of Medicaid for these groups is at the state's option. Generally, individuals covered under this category are AFDC-related individuals whose income and resources are within AFDC standards, but do not meet certain qualifying AFDC criteria. The majority of recipients under this category are dependent children whose family income and resources are within AFDC standards, but are not eligible for AFDC because of requirements under that program that one parent be unemployed, incapacitated, absent, or deceased. The federal government allows, but does not require, the state to provide Medicaid coverage up to 21 years old.

Figure III-16.

Federal Medicaid Requirements

Eligiblity for Coverage and Services



Source: LPR&IC Staff Analysis.

Medically-Needy

Coverage of individuals that qualify within the medically needy category is entirely at state option. In general, the same groups of individuals are covered as those under the categorically needy category; however, their incomes are too high to qualify under the categorically needy groups. If a state offers the program, the state sets the qualifying levels for income and assets, within federal guidelines. Individuals can qualify for Medicaid if income is reduced to the established level because of medical expenses. Once an individual reduces income to the medically needy income level, Medicaid coverage is provided. This is known as "spenddown" and is allowed only on income, not on assets. Thus, if an individual is above the asset limit set for the medically needy, the person will not receive coverage.

Furthermore, although the program is optional, if the state elects to operate a medically needy program, coverage **must** be provided to: pregnant women, including coverage for 60 days following the birth of the child; children under 1 year old whose mother continues to qualify for Medicaid benefits; and children 1 through 18 years old, meeting the medically needy income and asset limits. Currently, 41 states and territories provide medically needy coverage.

Transfer of Assets

Provisions were included under Medicaid law that allow states to deny coverage to aged, blind, or disabled persons entering long-term care facilities, who dispose of their assets for less than fair market value in order to gain Medicaid coverage. The intent behind the provisions was to prevent individuals from transferring substantial assets to their families in order to meet Medicaid eligibility levels. Public Law 100-360 created a new national transfer of asset policy with respect to institutionalized individuals, which became effective July 1, 1988. States are required to determine at the time of an application for benefits whether an institutionalized individual has disposed, within the preceding 30 months, of assets for less than fair market value. If a transfer occurred, a period of ineligibility is established. Transfer of assets is allowed only under the following circumstances:

- applicant's home is transferred to a spouse, child under 21 years old, blind or disabled adult child, or sibling who has an equity interest in the home and was residing in the home for at least a year prior to the applicant's admission to a nursing home;
- assets were transferred to the community spouse or blind or disabled child; or
- a satisfactory showing is made either that the individual intended to dispose of resources at fair market value or resources were transferred for a purpose other than to qualify for Medicaid.

States can only apply transfer of assets restrictions in accordance with these provisions. They cannot impose more restrictive or less restrictive criteria.

In Connecticut, both Medicaid applicants and recipients who become institutionalized are examined from the date of institutionalization to determine whether assets have been transferred for less than fair market value within the preceding 30 months. In addition, Public Act 92-79 requires the commissioner of DIM to request a waiver from federal law for the purpose of reducing long-term care costs by extending to 60 months the look-back period or penalty period imposed when assets are transferred for less than fair market value, except when exempted under federal law.

Scope of Service

All children under 21 years of age who are eligible for Medicaid must receive early and periodic screening, diagnosis, and treatment (EPSDT) services. Medicaid law requires that even if certain services are not covered under the states' Medicaid plan, they must be provided to EPSDT recipients. In addition, Medicare beneficiaries must receive any service covered under Medicare. For all other coverage groups, Medicaid law draws a distinction between required and optional services. All states must provide coverage for a core group of services for the categorically needy. All these services are referred to as "mandatory services." In addition, states may elect to provide a broad range of additional services to the categorically needy. These services are referred to as "optional services." Federal law also places certain requirements on the types of services states are required to provide if they have a program for the medically needy, which differ considerably from those applicable for the categorically needy (except for EPSDT services and those to Medicare beneficiaries).

Furthermore, states may limit the extent of service coverage to both coverage groups, as long as the four federally mandated requirements are met by the states:

- amount, duration, and scope - each covered service must be sufficient in amount, duration, and scope to reasonably achieve its medical purpose;

- comparability - services available to any categorically needy group must be equal in amount, duration, and scope to those available to any other categorically needy beneficiary in the state (similarly, services available to a medically needy group must be equal in amount, duration, and scope to those available to all other medically needy groups);

- statewide coverage - amount, duration, and scope of services, must be the same statewide; and

- freedom-of-choice - beneficiaries may obtain services from any institution, agency, pharmacy, person, or organization that agrees and is qualified to perform the services.

States are required to provide much broader medical services to the categorically needy than those required for the medically needy. Table III-11 lists the services that must be provided to the categorically needy and compares them to those required for the medically needy, if a medically needy program is offered by the state.

As shown in the table, states must provide a comprehensive array of services to the categorically needy. Conversely, coverage mandated by the federal government for the medically needy is much less inclusive.

Table III-11. Comparison of Federally Required Services between Categorically Needy and Medically Needy.

Required Categorically Needy Services	Required Medically Needy Services
inpatient hospital services	prenatal and delivery services for pregnant women
outpatient hospital services	ambulatory services for individuals under age 18 and for individuals entitled to institutional services
rural health clinic services	home health services for any individual entitled to Skilled Nursing Facility services
laboratory and x-ray services	if coverage is provided for persons in intermediate care facilities for the mentally retarded or services in institutions for mental diseases, all groups covered under the medically needy program must receive 7 of the services provided to the categorically needy
nursing facility services (over 21 years old)	early and periodic screening, diagnosis, and treatment (EPSDT) services (under 21 years old)
home health services (over 21 years old and entitled to nursing facility care)	services covered under Medicare for Medicare Beneficiaries
physician's services	
early and periodic screening, diagnosis, and treatment (EPSDT) services (under 21 years old)	
family planning services	
nurse-midwife services	
ambulatory services furnished by federally qualified health centers	

Source of Data: Medicaid Source Book: Background Data and Analysis. Congressional Research Service, Nov. 1988.

In addition to provision of required medical services, there are 31 categories of optional services. Optional services can be provided to categorically needy individuals only, or both categorically and medically needy persons. Table III-12 provides a comparison of optional medical services offered in each state and U.S. territories.

Of the 31 optional services, Connecticut provides 27 (see Table III-13). Seventeen states offer more optional services than Connecticut, while 35 states and territories offer less.

Table III-12 also shows those states where optional services are provided only to the categorically needy, and states that provide these services to both categorically and medically needy groups. Connecticut offers the identical benefit package of required and optional services to both groups. The figure provides a useful illustration of the options that states may exercise in choosing what services to offer, as well as the population groups covered. The figure shows the tremendous variety that exists among the states -- not only in terms of who is covered, but also in the diverse mix of services states have elected to offer.

Cost-sharing charges and rate-setting: Each state has broad discretion in determining (within federally imposed upper limits, specific restrictions and other tests of reasonableness) the reimbursement methodology and resulting rate for services, except in institutional services and hospice care services. States use different payment approaches and standards to reimburse providers for services covered by Medicaid including fee schedules, prospective payment systems, and reasonable cost. States are allowed to impose "nominal" cost-sharing charges, as defined in Medicaid regulation, on Medicaid beneficiaries for all services with the following exceptions:

- children under age 18 (states may exempt children aged 18 to 21);
- services related to pregnancy;
- services provided to inpatients in hospitals, Skilled Nursing Facilities, Intermediate Care Facilities, or other medical institutions if such individuals are required to spend all their income for medical expenses except for the amount disallowed for personal needs;
- family planning or emergency services; and
- categorically needy Health Maintenance Organization (HMO) enrollees (states may exempt medically needy HMO enrollees).

States may choose to impose cost-sharing charges on some groups and not on others. Connecticut does not impose any cost-sharing charges on any Medicaid recipients.

Under Medicaid law, three statutory provisions must be followed in developing a payment system:

- providers must accept Medicaid reimbursement as payment in full (thus if a patient refuses to pay the cost-sharing charges, the provider cannot recover the cost-sharing amount from the state);
- Medicaid is secondary to any other health coverage, including Medicare; and
- payment methods and procedures must assure that payments will be consistent with "efficiency, economy, and quality of care."

In addition, Medicaid regulations require that a state's payment rates must be sufficient to attract enough providers so that covered services will be as accessible to Medicaid beneficiaries as they are to the general population.

Table III - 12

Optional Services in State Medicaid Programs*

* CN[1]
+ Both CN and MN[2]
FMAP[3]
Basic Required Medicaid Services See Above

Key to Medicaid Determination column: (See reverse side for explanation.)
- 1634 State
- SSI-criteria State
- 209 (b) State
- Not applicable

FMAP[3]	CN[1] / Both CN and MN[2]	Key to Medicaid Determination column		Podiatrists' Services	Optometrists' Services	Chiropractors' Services	Other Practitioners' Services	Private Duty Nursing	Clinic Services	Dental Services	Physical Therapy	Occupational Therapy	Speech, Hearing and Language Disorders	Prescribed Drugs	Dentures	Prosthetic Devices	Eyeglasses	Diagnostic Services	Screening Services	Preventive Services	Rehabilitative Services	Age 65 or Older in IMDs[4]: A. Inpatient Hospital Services	Age 65 or Older in IMDs[4]: B. NF Services	ICF Services for Mentally Retarded	Inpatient Psychiatric Services for Under Age 21	Christian Science Nurses	Christian Science Sanitoriums	NF Services for Under Age 21	Emergency Hospital Services	Personal Care Services	Transportation Services	Case Management Services	Hospice Care Services	Respiratory Care Services	Total Additional Services	
72.93	•		Alabama		•		•		•					•		•	•					•		•				•					14	AL
50.00	•		Alaska		•	•			•	•	•	•	•	•		•	•					•		•	•			•	•	•	•			17	AK
50.00	+		American Samoa[4]			+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+								+					17	AS
62.61	•		Arizona[5]	•	•		•	•	•	•	•	•	•	•	•	•	•							•				•	•	•	•	•	•	20	AZ
75.66	+		Arkansas		+	+	+	+	+	+	+	+	+	+	+	+	+				+	+	•	•	+				•	+	•	+	+		23	AR
50.00	+		California	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	30	CA
54.79	•		Colorado	•	•		•	•	•					•		•	•					•	•	•	•			•	•		•	•	•	18	CO
50.00	+		Connecticut	+	+	+	+		+	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+		+	+			+	+		24	CT
50.12	•		Delaware	•	•		•	•	•					•		•	•	•				•	•	•				•	•			•		16	DE
50.00	+		D.C.	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+				+	+					23	DC
54.69	+		Florida	+	+	+	+	+	+	+	+	+	+	+	+	+	+				+	•		•				•	+	+	+	+	+	24	FL
61.78	+		Georgia	+	+		+		+	+				+	+	+	+							+				+			+	+	+	14	GA
50.00	•		Guam		•				•	•			•	•			•											•						7	GU
52.57	+		Hawaii	+	+		+		+	+	+	+	+	+	+	+	+	+	+	+	+			+	+			+	+		+	+	+	+	24	HI
73.24	•		Idaho	•	•	•	•		•		•			•							•		•	•				•	•	•	•	•	•	16	ID
50.00	+		Illinois	+	+	+		+	+	+	+	+	+	+	+	+	+	+		+	+	+	+	+	+		+	+	+		+		+	25	IL
63.85	•		Indiana	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•		•	•	•	•	•	•				•	28	IN
65.04	+		Iowa	+	+	+	+		+	+	+	+	+	+	+	+	+					•	•	•	•			•			+	+	+	21	IA
59.23	+		Kansas		+		+	+	+	+	+	+	+	+	+	+	+				+	+	+	+	+			+	+	+	+	+	+	23	KS
72.82	+		Kentucky	+	+		+		+	+	+	+	+	+		+		+	+	+	+	+	+	+	+			+	+		+	+	+	23	KY
75.44	+		Louisiana	•	+		•		+					+	+	+					+	•		•	•			•			+	+		14	LA
62.40	+		Maine	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+			+	+	+	+	+		+	+	+	26	ME
50.00	+		Maryland	+	+		+	+	+	+	+		+	+	+	+	+					+	+	+	+			+	+	+	+	+	+	22	MD
50.00	+		Massachusetts	+	+		+	•	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+			+	+	+	+	+	+	27	MA
55.41	+		Michigan	+	+		+		+	+	+	+	+	+	+	+	+	+			+	+	+	+	+		+	+	+	+	+	+	+	26	MI
54.43	+		Minnesota	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	+	+	+	+	+	+	29	MN
79.99	•		Mississippi				•		•	•	•	•	•	•		•	•	•	•	•	•					•	•	•		•	•			18	MS
60.84	•		Missouri	•	•				•	•				•	•	•	•				•	•		•	•			•		•	•	•	•	17	MO
71.70	+		Montana	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+			+	+	+	+		+	26	MT
64.50	+		Nebraska	+	+	+	+	+	+	+	+	+	+	+	+	+		+			+	+	+	+	+			+	+	+	+	+		24	NE
50.00	•		Nevada	•	•	•	•	•	•	•	•	•	•	•	•	•	•				•	•	•	•	•			•	•	•	•	•	•	25	NV
50.00	+		New Hampshire	+	+	+	+	+	+	+	+	+	+	+		+	+	+	+	+	+	+	+	+	+			+	+	+	+	+		26	NH
50.00	+		New Jersey[6]	+	+	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	•	•	•	•		•	•	•	•	•			26	NJ
74.33	•		New Mexico	•	•		•		•	•	•	•	•	•	•	•	•						•	•			•	•		•	•	•	19	NM
50.00	+		New York	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	+			+	+	+	+	+	+	26	NY
66.52	+		North Carolina	+	+	+		+	+	+				+	+	+	+	+	+	+	+	+	+	+	+			+		+	+	+	+	23	NC
72.75	+		North Dakota	+	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	+			+	+		+	+	+	25	ND
50.00	+		N. Mariana Islands[4]				+		+	+	+	+	+	+	+	+	+	+	+	+	+									+				15	NMI
60.63	•		Ohio	•	•	•	•	•	•	•	•	•	•	•	•	•	•				•		•	•	•		•	•		•	•	•		23	OH
70.74	+		Oklahoma	+	+		+		+	+				+		•	•			•	+	•		•	+			•		+	+	+		17	OK
63.55	+		Oregon[6]	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	+		+	+	+	+	+		+	28	OR
56.84	+		Pennsylvania	+	+	+			+	+				•	+	+	+				+	+	+	+	+			+	+		+	+	+	19	PA
50.00	+		Puerto Rico[7]						+																									1	PR
53.29	+		Rhode Island	•	+					+				+	+	+	•				+	+	+	+	+			+			+	+	+	16	RI
72.66	+		South Carolina	+	+		+		+	+	•	•		+		+	+				+	+	+	+	+			+	+		+	+		19	SC
72.59	•		South Dakota	•		•			•	•	•		•	•	•	•					•		•	•			•	•	•		•			16	SD
66.41	+		Tennessee	+	+		+		+	+				+		+					+	+	+	+	+		+	+	+		+	+	+	19	TN
64.18	+		Texas[5]	+	+	+	+		+		+			+		+	+	+			+			+			+	+	+		+	+	+	20	TX
75.11	+		Utah	+	+		+	+	+	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+			+	+	+	+	+		26	UT
61.37	+		Vermont	+	+	+	+		+	+	+	+	+	+	+	+	+				+	+	+	+	+			+	+		+	+	+	23	VT
50.00	+		Virgin Islands[7]						+																								+	2	VI
50.00	+		Virginia	+	+		+		+	+	+	+	+	+		+	+				+	•	•	•		+	+	+		+	+	+		21	VA
54.98	+		Washington	+	+	•	+	+	+	+	+	+	•	+	+	+	+	•		+	+	+	+	+	+			+	+	•	+	+	•	+	28	WA
77.68	+		West Virginia	+	+	+	+	+	+	+	+		+	+	+	+	+							+	+			+	+	+	+	+		+	21	WV
60.38	+		Wisconsin	+	•	•	•	•	+	•	+	+	+	+	•	+	•	•	•	•	•	•	+	•	•		+		+	+	+	+	+	+	30	WI
69.10	•		Wyoming		•		•		•	•	•		•	•		•	•				•	•		•				•	•		•			15	WY
•	15		•	12	14	8	13	8	15	12	11	8	11	16	8	14	16	5	4	3	12	14	11	21	10	1	4	20	14	9	14	10	9	3		
+	41		+	33	36	19	32	20	40	36	31	26	29	38	31	38	33	21	19	20	33	26	22	28	29	2	11	30	28	19	37	33	24	11		
	56		Total	45	50	27	45	28	55	48	42	34	40	54	39	52	49	26	23	23	45	40	33	49	39	3	15	50	42	28	51	43	33	14		

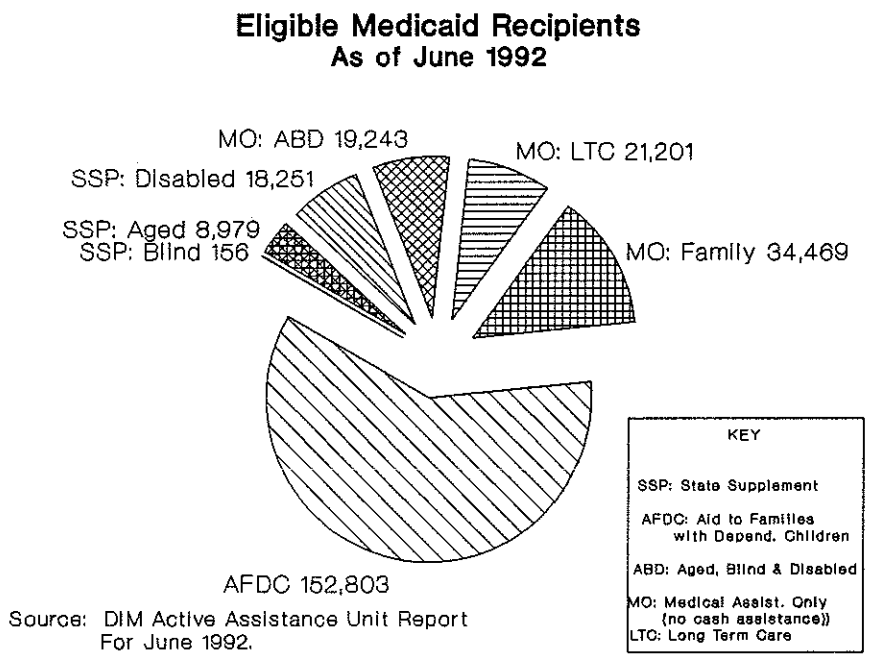
Table III-13. Connecticut Coverage of Federal Optional Medicaid Services.	
Optional Service	*Covered by CT*
Podiatrists' Services	yes
Optometrists' Services	yes
Chiropractors' services	yes
other practitioners' services	yes
private duty nursing (available to all under Home Health Agency Care)	yes
clinic services	yes
dental services	yes
physical therapy	yes
occupational therapy - (available through clinic services)	yes
speech, hearing and language disorders	yes
prescribed drugs	yes
dentures	yes
prosthetic devices	yes
eyeglasses	yes
diagnostic services	yes
screening services	yes
preventive services	yes
rehabilitative services	yes
Age 65 or older in Institutions for Mental Diseases: • inpatient hospital services; • nursing facility services	 yes yes
Intermediate Care Facilities for the Mentally Retarded	yes
inpatient psychiatric services for under age 21	yes
christian science nurses	no
christian science sanitoriums	no
nursing facility services for under age 21	yes
emergency hospital services (Option availabe only for hospitals not participating in Medicaid. Service automatically required for participating hospitals, which in CT all hospitals participate)	no
personal care services	no
transportation services	yes
case management services - (targeted for DMR & DMH)	yes
hospice care services (avail. through home/health care or hospital services)	yes
respiratory care services	yes
Source: HCFA Pub. No. 02155-92	

Recipient and Expenditure Data

Figure III-17 shows that an estimated 255,102 individuals were covered under Medicaid for the month of June 1992, slightly higher than the estimated annual monthly average for the year (FY 92) of 241,203. It is difficult to obtain the precise number of recipients covered under Connecticut's Medicaid program because of complications with DIM's eligibility management computer system. It is generally accepted that the data in Figure III-17 slightly underrepresents the actual number of those eligible by about 5 percent. The reason for this is that DIM's system does not provide an unduplicated count of recipients across all eligibility categories; therefore, adjustments must be made in order to obtain a reliable estimate.

Figure III-17 divides Medicaid's multiple coverage groups into individuals who receive: AFDC; State Supplemental; and Medicaid only, but no public cash assistance. As the figure shows, 152,803 (60 percent) of the Medicaid recipients in June 1992 were also recipients of AFDC. The third largest Medicaid group (21,201) was comprised of individuals who reside in long-term care facilities. State supplement recipients accounted for 11 percent of the individuals on Medicaid. Fully 29 percent of all individuals covered under the Medicaid program received no public cash assistance.

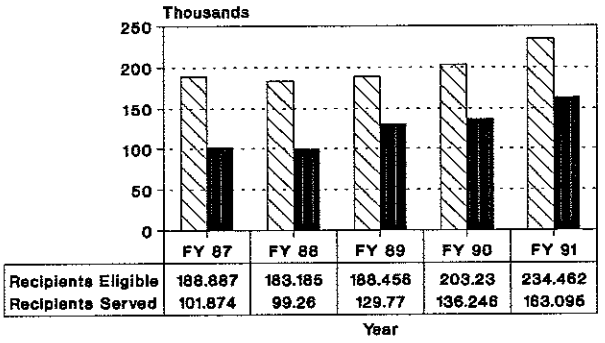
Figure III-17



Not all individuals who are covered by the Medicaid program during any given period use the services for which they are eligible. Figure III-18 compares the number of individuals covered under Medicaid and those who actually used the services over the past five fiscal years. Individuals eligible for Medicaid have grown more then 45,000 (24 percent), during that period,to a total of 234,462 for 1991. This may be attributable to the impact of the poor economic climate in Connecticut, thus allowing more individuals to meet the eligibility criteria. More importantly, the number of individuals who actually used Medicaid services increased by 61,221 -- a 60 percent increase over the four years. Growth remained relatively stable in FY 87 and FY 88 and then increased rapidly through FY 91.

Figure III-18.

Comparison of Recipients Eligible to Recipients Served (average monthly)



	FY 87	FY 88	FY 89	FY 90	FY 91
Recipients Eligible	188.887	183.185	188.456	203.23	234.462
Recipients Served	101.874	99.26	129.77	136.246	163.095

Year

Recipients Eligible Recipients Served

Source: Governor's Budget.

FY 92 data: not available

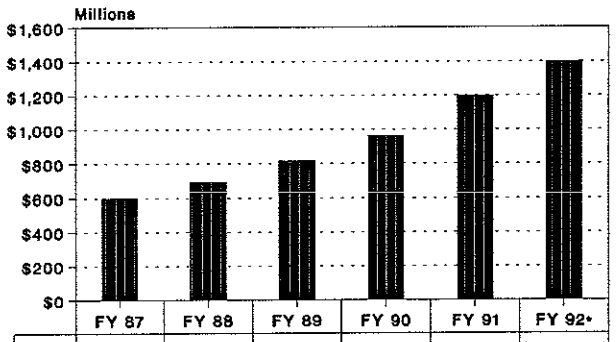
The percentage of individuals served under Medicaid compared to those eligible has also grown over the past five years. In FY 87 and FY 88, 54 percent of Medicaid-eligible recipients actually used services. However, that ratio grew to 69, 67, and 70 percent respectively in FY 89, FY 90, and FY 91.

Total Medicaid expenditures for FY 92 were more than double the amount of five years ago. Figure III-19 shows Medicaid expenditures since FY 87, during which time expenditures increased 133 percent, exceeding $1.3 billion by FY 92.

One explanation for the large increase in expenditures may be the increase in the number and type of individuals using Medicaid services. Other possible reasons include the types of services being used are more costly, overall increases in cost of care, or a combination of the three factors.

Figure III-19.

Total Medicaid Expenditures
FY 87 - FY 92*



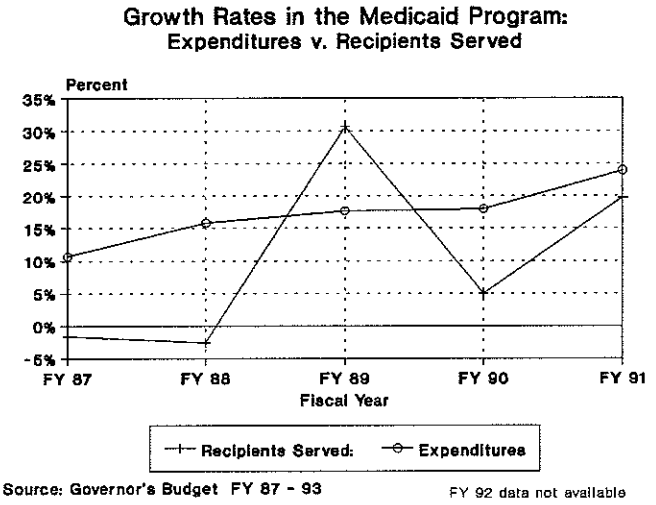
	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92*
	$599.088	$693.815	$816.526	$964.669	$1,195.614	$1,398.424

Year

*FY 92 is appropriated amount.
Source: Office of Fiscal Analysis Budget

Figure III-20 compares growth rates in expenditures and number of individuals who used Medicaid services (as opposed to those who are merely eligible). As the figure shows, between FY 87 and FY 91, the expenditures increased at a greater rate than recipients served in every year except FY 89. In FY 89 there was a 30 percent increase in recipients using services compared to an 18 percent increase in expenditures.

Figure III-20.



The relationship between the number of recipients and the share of payments for each eligibility group in Connecticut for June 1992 is presented in Figure III-21. AFDC recipients comprise approximately 60 percent of eligible recipients; however, they account for only 17 percent of Medicaid expenditures. Conversely, only 8 percent of Medicaid recipients receive long-term care services, but they account for almost 50 percent of expenditures.

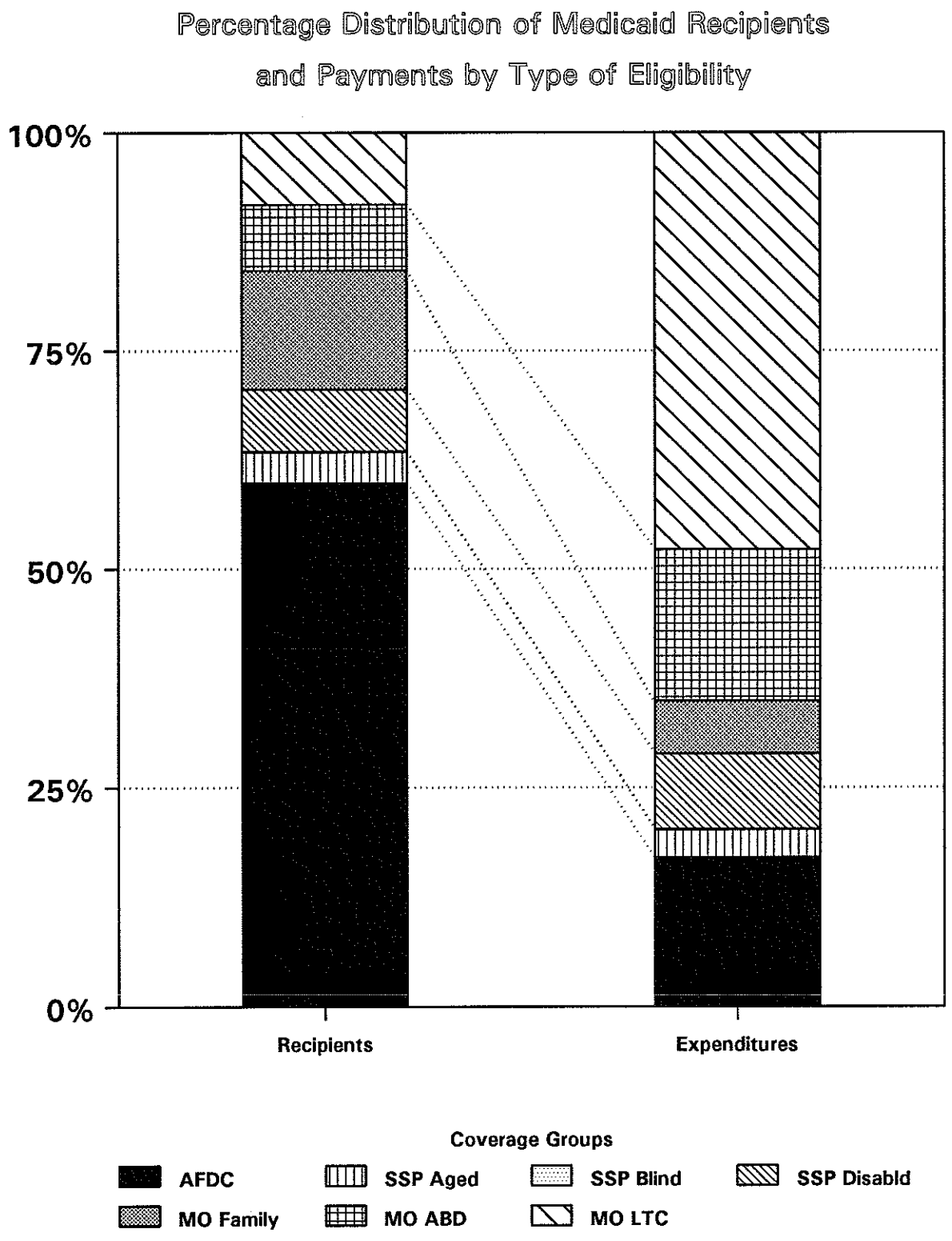
National Data

Table III-14 shows the average cost expended for each category of Medicaid beneficiaries. Connecticut, on average, expends significantly more than the national average for each of the client groups (except AFDC adults). The greatest differences in expenditures occur with the aged and disabled populations, where the difference is in excess of $6,000 per recipient.

There are several factors that may explain the reason why average Connecticut expenditures exceed the U.S. average. The types of individuals receiving Medicaid, as well as the amount, duration, scope, and cost of services are quite varied among states. Connecticut provides several optional services to both mandatory and numerous optional coverage groups, which may also account for the difference.

Table III-15 shows Medicaid expenditures as a percentage of several northeastern states' budgets in fiscal years 1987 to 1991, as well as the expenditure increases in those years. Vermont had the largest increase from FY 87 to FY 91 (96 percent), followed closely by Connecticut at 95 percent. Furthermore, by 1991 a larger portion of General Fund expenditures (ranging from 12.1 percent in Connecticut to 20.2 percent in Rhode Island) were used for Medicaid in each of the states. However, the ability of states to control other aspects of their budgets would have a major impact on Medicaid becoming a larger percentage of General Fund expenditures.

Figure III-21.



LPR&IC Staff Analysis.

As of June 1992.

Table III-14. Average FY 90 Expenditure per Recipient by Basis of Eligibility.			
Coverage Group	U.S. Average (Per Recipients)	CT Average (Per Recipients)	Difference Between U.S. & CT Average
Aged	$6,719	$13,001	($6,282)
Blind	$5,253	$8,726	($3,473)
Disabled	$5,933	$12,750	($6,817)
AFDC Children	$899	$1,792	($893)
AFDC Adults	$1,523	$762	$761
Other Title XIX	$1,695	$3,033	($1,338)
TOTAL	$2,700	$4,829	($2,129)
Source: U.S. Congress, House Ways and Means Committee, 1992 Green Book.			

Table III-15. Medicaid expenditures as a Percent of General Fund Expenditures: A Comparison.					
State	Amount 1987 (in millions)	% General Fund Expenditures FY 87	Amount 1991 (est.) (in millions)	% General Fund Expenditures FY 91	Percent Increase in Medicaid FY 87-FY 91
CT	$600	8.6%	$1,170	12.1%	95%
ME	$283	14.6%	$445	15.3%	57%
MA	$1,423	9.7%	$2,581	15.0%	81%
NH	$144	12.7%	$258	17.7%	79%
NJ	$1,551	11.7%	$2,646	14.6%	71%
NY	$6,330	17.6%	$9,639	19.6%	52%
RI	$293	17.9%	$463	20.2%	58%
VT	$98	10.4%	$192	14.9%	96%

* Dollar figures represent total Medicaid expenditures. Percent figures represent the state portion of Medicaid financing before deducting the federal reimbursement. (In Connecticut, federal reimbursement equals 50 percent.)

Source: Medicaid Intergovernmental Trends and Options.
Advisory Commission on Intergovernmental Relations, Washington, D.C. (June 1992).

Federally required coverage groups are shown in the first column. In the second column, all federally optional groups are shown; however, those that Connecticut has extended coverage to are in bold highlight. Those groups not in bold highlight are not covered in Connecticut.

Exhibit MED-1. Mandatory and Optional Recipients of Medicaid.

Required Federal Coverage Groups (Categorically Needy)	Optional Federal Coverage Groups (Categorically Needy)
• **AFDC Children and Adults Including:** - AFDC unemployed parents; - AFDC pregnant women with no other children; and - AFDC children who are 18 and full-time vo-tech or secondary students. • **AFDC-Related not Receiving AFDC because:** - amount would be less than $10; - payments would be $0 because of overpayment recovery; - certain work supplementation participants; - certain children whom adoption assistance agreements are in effect or whom foster care payments are being made under Title IV-E; • individuals who would be eligible for AFDC except for an increase in 1972 of Old Age Survivor Disablity Insurance (OASDI) benefits; • Persons ineligible for AFDC because of a requirement that may not be imposed under Medicaid; and • certain families whose AFDC has been terminated after receiving benefits in at least 3 of the preceding 6 months because: - increased income from employment or hours (12-month extension); - increased child or spousal support (4-month extension)	• **individuals eligible for, but not receiving AFDC, SSI, or an optional state supplement, including those in medical institutions;** • **individuals who have become ineligible for Medicaid while enrolled in an HMO, state may complete remainder of any 6-month payment (however, there are no currently active contracts in CT);** • **individuals who would be eligible for AFDC if their child care cost were paid from earnings rather than by a state agency;** • individuals who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under title IV-A (Not Applicable - Connecticut's is as broad).

Exhibit MED-1. Mandatory and Optional Recipients of Medicaid.

Required Federal Coverage Groups (Categorically Needy)	Optional Federal Coverage Groups (Categorically Needy)
Pregnant Women and Children not Receiving AFDC • all children under 19 (born after 9/30/83 phase-in period - so by year 2003 all under 19 covered) and whose family income is below 100% of the poverty level; • pregnant women and children under age 6 with family incomes below 133% of the poverty level; • women who received Medicaid while pregnant continue to be eligible for pregnancy-related and postpartum services for 60 days after end of pregnancy; and • newborns and infants born to women eligible for and receiving Medicaid at time of the birth. Child is eligible for one year as long as mother continues to be eligible.	• **pregnant women, and infants: under one,** two, three, four, or five years old **with incomes above 133% of the poverty level but no more than 185% (Once offered, coverage for this group becomes mandatory);** • **children whose income and resources are within AFDC standards but do not meet "dependent child" definition. Age of coverage is up to 18, 19, 20, or 21 years old at the state's option. State can limit coverage to reasonable subgroups (e.g. foster children, individuals in psychiatric facilities, nursing facilities, or intermediate care facilities for the mentally retarded, etc.); (CT covers all subgroups.)** • **states AFDC program is not as broad as permitted under federal law (however, CT AFDC program is as broad);** • a child for whom there is in effect a state adoption assistance agreement (rather than title IV-E) who cannot be placed because of special needs without medical assistance and was eligible for Medicaid under a state plan or would have been eligible if title IV-E standards were being used rather than AFDC.

Exhibit MED-1. Mandatory and Optional Recipients of Medicaid.

Required Federal Coverage Groups (Categorically Needy)	Optional Federal Coverage Groups (Categorically Needy)
SSI-Related Groups: • SSI recipients OR those individuals who are blind, and/or disabled who were eligible for Medicaid in December 1973 and continue to meet the 1973 criteria (no coverage for disabled children under 18 years old); • persons who would be eligible for SSI or state supp. except for requirements that do not apply under Medicaid law; • persons who received SSI and/or SSP but who lost eligibility solely because of a cost-of-living social security increase; • certain persons who lose SSI because of increases in Social Security or veterans' benefits (however **not** mandatory in CT because of 209(b) state status); • "qualified severely impaired" persons who lost SSI or SSP eligibility because of employment earnings; still have disability and meet SSI criteria except for income (Section 1619(a) & (b) of the Social Security Act); • individuals receiving mandatory state supplement; • blind or disabled persons over 18 years old who lose SSI eligibility because they become entitled to or have an increase in OASDI child benefits, but would still be eligible for SSI absent OASDI benefits (not mandatory in CT because of 209(b) state status); • disabled widows and widowers meeting certain criteria.	• **persons not receiving SSI but receiving State-only supplement;** • certain disabled children age 18 or under who are living at home, who would be eligible in a medical institution for SSI or SSP; • aged or disabled individuals whose income does not exceed 100% of poverty level and resources do not exceed the maximum allowed under SSI or under Medically Needy Income Level.

Exhibit MED-1. Mandatory and Optional Recipients of Medicaid.

Required Federal Coverage Groups (Categorically Needy)	Optional Federal Coverage Groups (Categorically Needy)
Qualified Medicare Beneficiaries (QMB) and Related Groups: • receiving Medicare, income is below 100% of the poverty level, and resources do not exceed twice the allowable amount under SSI (state must also pay Medicare part A and B premiums, along with Medicaid coinsurance and deductible amounts); • persons meeting the definition of QMB's except their incomes are between 100 and 110% of the poverty level (effective 1/93); • state must pay, under Medicaid program, part A Medicare premium for persons who have lost eligibility for SSI and Medicaid benefits, have incomes below 200% of the poverty level and resources no greater than twice the SSI standard. (QDWI) Medical assistance limited to payment of Medicare part A.	• full Medicaid benefits rather than just Medicare premiums and cost sharing to QMB's who meet state-established income standard no higher than 100% of federal poverty level.
Institutionalized Persons and Related Groups: • institutionalized individuals who were eligible in Dec. 1973 as inpatients if, for each consecutive month since, they continue to meet the 1973 criteria, remain institutionalized and continue to need that level of care.	• **individuals who are institutionalized for at least 30 days are eligible under a special income level which cannot exceed 300% of the maximum SSI benefit;** • **persons who would otherwise require institutional care and be receiving Medicaid, if they were not receiving alternative services at home or in the community;** • **persons that would otherwise qualify for AFDC, SSI, or SSP, except they are in a medical institution;** and • individuals who would be eligible for Medicaid if they were in a medical institution, who are terminally ill, and who receive hospice care.

Exhibit MED-1. Mandatory and Optional Recipients of Medicaid.

Required Federal Coverage Groups (Medically Needy)	Optional Federal Coverage Groups (Medically Needy)
Individuals whose income is too high to qualify under a categorically needy coverage group are eligible under the medically needy group. In order to qualify under the medically needy program, an individual must reduce income by spending on medical care to an income level established by the state within federal guidelines. Once income is reduced to this income level, Medicaid coverage is provided. ***Medically needy program is optional, but if offered, these groups MUST be covered:*** • **all pregnant women who would qualify under either a mandatory or optional group if their income or resources were lower;** • **pregnant women who have given birth qualify for an additional 60 day extension of coverage;** • **newborn children born to a woman receiving Medicaid on child's birth. Child is eligible for 1 year; and** • **children under 18, 19, 20, or 21 years old (optional age limit) who would qualify under a categorically needy group if income or resources were lower (CT uses 21 years old).**	• **caretaker relatives of eligible children;** • **aged, blind, and disabled individuals who would be eligible under a categorical coverage group except for income and resources;** • **individuals under 18 whose coverage as categorically needy would be mandatory if not for income and resurces;** • **individuals who were initially eligible for enrollment in an HMO continue eligibility for remaineder of enrollment period (6 months); and** • **blind and disabled individuals who meet the Dec. 1973 blind and disabled criteria and were eligible as medically needy in Dec. 1973.**

GENERAL ASSISTANCE

Program purpose: To provide cash and medical assistance to individuals or families (who are ineligible or are qualified but have not yet begun receiving AFDC benefits) who have insufficient income and/or assets to meet their essential needs including food, shelter, clothing, utilities, and medical assistance.

Administering agency: The Department of Income Maintenance oversees the administration of General Assistance throughout the state and reimburses Connecticut's 169 towns for program costs. Public Act 92-16, May Special Session, requires that General Assistance be fully state-administered by July 1994.

Statutory authority: Chapter 308, Sec. 17-272 through Sec. 17-292f of C.G.S.
Chapter 299, Sec. 17-3a of C.G.S.; Public Act 92-16

Program requirements: There are no federal requirements for the program, and no federal funds support GA. The program is administered by the towns, and is funded jointly by the state and the towns. State statutes require that all towns provide GA, and that towns have a plan approved by DIM on how the program will be operated. The Department of Income Maintenance has developed regulations that establish policies and procedures that towns must follow in taking applications, determining eligibility, and operating the program. Audits of the program are conducted by DIM to ensure that towns are providing assistance according to state law and department regulations, and that claims for state reimbursement are accurate.

Public Act 92-16 of the May Special Session requires that towns also submit an employability plan, as part of its overall GA plan. It must explain how the town intends to assess each recipient's employability and develop a plan for enhancing opportunities in the workforce for employable recipients (as defined below).

State caseload: FY 91 Average Monthly Caseload - 22,686 recipients
FY 92 Average Monthly Caseload (to March) - 33,551 recipients

Benefit levels: average monthly benefit (FY 91):
$293 single recipient
$360 family

Total expenditures: The total cost for all assistance provided under the GA program for FY 91 was $117,029,782, with the state portion of the expenses totalling $114,084,077. Of the entire GA costs, $84,313,734 went to cash assistance, while $39,097,252 was for medical assistance, and $5,182,610 supported other assistance, such as burial and emergency shelter expenses. Although all the caseload and expenditure data are not yet available for FY 92, the data to date indicate there will be a significant increase in GA cases and expenses for FY 92. (See Figure III-23 for expenditure trends).

State reimbursement: In past years, the state reimbursed towns for 90 percent of their GA costs, with additional reimbursement for added workfare hours and for administrative costs for workfare. As of July 1992, the reimbursement rate has been decreased to 85 percent. Towns must use authorized forms and submit their bills to the Department of Income Maintenance quarterly for reimbursement.

Program description: There are three basic General Assistance benefits that a recipient is eligible to receive:

- financial aid;
- medical aid (direct payment to medical providers may be granted alone or in combination with financial aid); and
- burial expenses.

In addition, P.A. 92-16, May Special Session, continues to provide emergency shelter to recipients of General Assistance, but only if they have not left housing voluntarily. Emergency shelter recipients are also required to perform a housing search. (A recipient must provide the town with documentation of applications for three rentals each week.)

Eligibility Criteria

General program

- Complete an application;
- Comply with certain other requirements specific to the applicant's situation (e.g. substance abuse treatment); and
- Participate in workfare, or other training and education, if applicable.

Residency

- Reside in the town where he/she is applying (except if person is homeless or has been deinstitutionalized);
- Must be a citizen of the United States or a legal entrant with immigrant or refugee status (P.A. 92-16, May Special Session); and
- Must be a resident of Connecticut, although there are no durational requirements, and must not have a domicile in another state or country (P.A. 92-16, May Special Session).

Income and assets

- Demonstrate need, with countable income less than the standard of need set for that region (other types of assistance, like food stamps, are not

considered countable income);

- Demonstrate that assets do not exceed $250 per person, or $1,000 per assistance unit (excludes car valued at $1,500 or less);
- Cooperate in pursuing other resources or assistance;
- Transfer of assets within 24 months prior to receiving or while receiving GA may make the person ineligible; and
- If the GA recipient owns a house, the town may place a lien against it for recoupment of assistance paid.

Caseload profile

Some characteristics of the GA recipient for FY 91 were:

- 59 percent of recipients male;
- average age of recipient head of household 35 years old;
- average education level 10 years;
- recipient never married (61 percent);
- more than half of recipients lived in the state (62 percent) and town (51 percent) for 10 years or more;
- 44 percent Black, 31 percent Hispanic, and 24 percent White;
- 26 percent substance abusers; and
- 10 percent had some military history.

The data used in the profile were compiled by the Department of Income Maintenance. They were drawn from a random sample of about 3 percent of the active caseload, and were collected in the 23 largest towns in Connecticut.

Program Requirements

As a result of Public Act 92-16, May Special Session, the law now requires that the General Assistance program distinguish between employable and unemployable persons. Program requirements, as well as a definition of each type, are provided below:

Employable person

- age 16 or older, or less than 65;
- no documented physical or mental impairment, or such impairment is expected to last less than 6 months, prohibiting him or her from working or participating in an education, training, or other work-readiness program; and
- required to register with Department of Labor if the recipient is not in full-time attendance in high school.

Unemployable person

- under 16, age 65 or older, or 55 years of age or older with a history of chronic unemployment;
- has a physical or mental impairment certified by a physician as preventing the person from participating in any type of employment, education, or training for at least six months;
- is pending receipt of Supplemental Security Income, Social Security Income, or financial assistance through another DIM program;
- is needed to care for a child under 2 years old or an incapacitated child or spouse; or
- is a full-time high school student.

General Assistance is not given to an employable person (except over 65 years old, health reasons, or other disability) who:

- has not registered with local employment agency of the Department of Labor;
- refused to accept a position for which he or she is fitted and which the recipient is able to accept; or
- has refused to participate or wilfully failed to report for work in a work program or training or education program.

In FY 89, the number of employable GA recipients was 3,953, which comprised 32 percent of the total GA caseload. By FY 91, that number had nearly tripled to 10,571, about 47 percent of the total caseload.

Durational requirements: Public Act 92-16 of the May Special Session requires that employed persons be limited to receiving GA financial assistance for 9 months of every 12-month period. A town can extend the assistance up to 3 months, if the recipient is in compliance with program requirements. Persons with dependent children under 18 years old who are eligible for GA, but ineligible for other public assistance programs are not subject to the 9-month durational limit. The durational limits do not apply to medical assistance as long as the person still meets the other eligibility requirements.

Level of Assistance

Cash assistance: single cases. Until June of 1992, cash assistance for all GA recipients was based on a standard of need (established by DIM and identical to the AFDC standard of need), depending on the region in which the client resided. Once the need level was determined, the towns could subtract any client income from it to arrive at a benefit level. Towns were allowed, however, to pay less than what was determined to be the full rent component. Public Act 92-16, May Special Session, changed the manner of determining assistance for single

recipients. Effective July 1, 1992, all single recipients are awarded a flat grant, regardless of expenses. Single recipients will still have to meet a needs standard in order to determine eligibility, but all single recipients will receive one of two monthly amounts based on the individual's employability status. These are:

- $314 - per month for single employable person; and
- $356 - per month for a single unemployable person.

P.A. 92-16 of the May Special Session eliminated the incentive payment for additional hours worked in the Workfare program, and single recipients are no longer eligible for the $50 payment for excess shelter costs. However, recipients' flat grants cannot be reduced if they are in emergency housing situations.

Cash assistance: family cases. The level of assistance for family cases will continue to be determined based on the flat grant specified for that region. The flat grant ranges from a low of $573 for a family of three in Region C, to a high of $680 for a family of 3 in Region A. Family cases include married couples, with or without dependent children, and pregnant women. Only family cases will continue to qualify for an additional $50 per month if their shelter costs are more than half their monthly benefit.

Medical Assistance

Mandatory coverage groups

- those persons receiving General Assistance (P.A. 92-16, May Special Session, requires those under age 21 or over 65 to apply for Medicaid);
- those eligible to receive GA;
- those unable to pay for medically necessary services over a two-year period (in compliance with the transfer of assets provision and with regulations for ability to pay);
- those on General Assistance but in a work program subsidized by the Department of Labor (PA 92-16, May Special Session); and
- those no longer eligible for cash assistance because of employment are eligible for medical assistance for up to three months (P.A. 92-16, May Special Session).

Mandatory medical services

The medical services that are required under GA are listed below, and are the same as those required under the state's Medicaid program. Public Act 92-16 of the May Special Session limits reimbursement of services to those provided under the state's Medicaid program. The services are:

- physician services;
- hospital services on an inpatient basis and outpatient care;
- community clinic services;
- prescription drugs;

- glasses;
- hearing aids;
- laboratory and x-ray services;
- emergency dental services;
- emergency medical transportation;
- convalescent home services for persons who were receiving such services paid for by a town prior to January 1, 1983; and
- medical examinations needed to determine employability for a work program, required by a prospective employer but not paid for by such employer, or requested by an attorney to establish SSI eligibility for a person receiving GA.

As a result of the 1992 legislation all medical providers must be enrolled as Medicaid providers. Electronic Data Systems (EDS), the same vendor with whom the state contracts for all other Medicaid payments, will process GA medical bills, provide payment directly to the vendor, and subsequently bill the town for its 15 percent reimbursement.

Substance Abuse Treatment

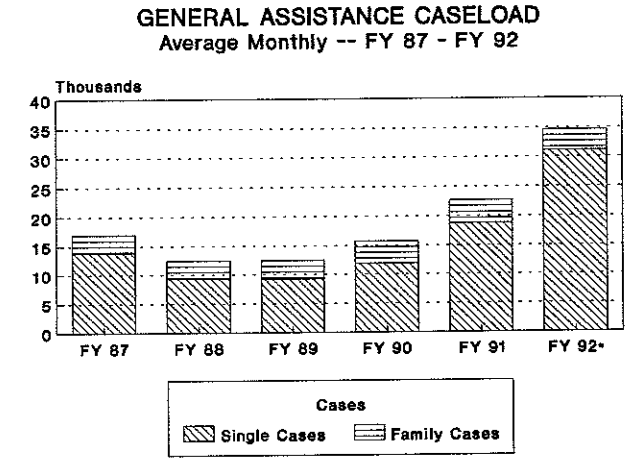
Public Act 92-16, May Special Session, also requires any GA recipient or applicant who is a substance abuser to seek treatment, as specified in regulations, in order to receive financial assistance. Payment for the cost of the treatment is from a variety of sources including the General Assistance program, CADAC, or the town in which the individual resides.

Caseload and Expenditure Trends

Caseload: General Assistance has grown dramatically over the past several years. From 1987 to 1992 the caseload doubled -- growing from almost 17,000 to more than 34,000. The most significant growth occurred over the past three fiscal years, increasing 120 percent from FY 90 to FY 92. As figure III-22 shows, almost all the growth has been in the single recipient category compared to family cases. There are two primary reasons for this. First, GA family cases are often eligible for another type of assistance like AFDC, or AFDC-UP, and only receive GA for the short time until they begin receiving other benefits. Thus, turnover in family cases is high, and the overall number of those cases has not significantly increased since FY 87.

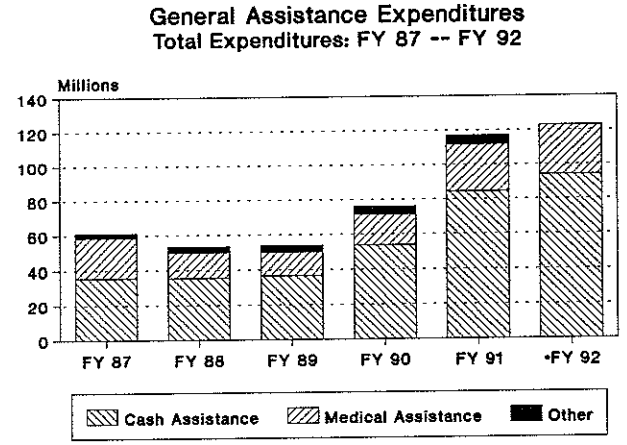
Furthermore, General Assistance has always been considered the assistance program of last resort, and thus most of the single recipients are unlikely to be eligible for any other type of benefits. Some of the single recipients have depleted other assistance, such as unemployment insurance, and as a result, are receiving GA benefits. However, there is a core GA caseload that does not leave the rolls. These two factors cause the overall caseload to increase when the economy declines and unemployment increases

Figure III-22.



Expenditures: Expenditures have increased even more rapidly than the caseload. Figure III-23 shows total GA expenses since FY 87. As the figure shows, expenditures actually decreased from FY 87 to FY 88, and remained static in FY 89. The sharp increase in expenditures has occurred over the past three fiscal years, with expenses for the first three quarters of FY 92 already surpassing those for all of FY 91.

Figure III-23.



Levels of Assistance: As was mentioned earlier, until July of this year, benefit levels for all recipients were based on need. Towns could take into account the recipient's rent and prorate that rent if the client was sharing shelter expenses, or exclude it altogether if the client was living in an emergency shelter. This tended to yield a wide range of benefit levels. This variance is shown in Table III-16, which presents the percentage of sample cases that fall into each benefit category. As would be expected, the family cases tend to be paid at higher benefit levels. Also of note is the increasing percentage of single recipients that are paid over $300. In 1988, that was 45 percent; in 1991 it had grown to 65 percent. Of course, the range in benefit levels for single cases will now be eliminated as a result of P.A. 92-16 of the May Special Session, which requires all single recipients to be paid either $314 or $356.

Table III-16. General Assistance: Percentage of Sample Cases At Various Benefit Categories.

Benefit Category	1988		1989		1990		1991	
	Single (N=276)	Family (N=66)	Single (N=285)	Family (N=61)	Single (N=358)	Family (N=88)	Single (N=427)	Family (N=45)
$0-$100	3%	0	4%	0	4%	1%	5%	0
$101-$200	31%	6%	30%	7%	22%	1%	22%	0
$201-$300	20%	3%	13%	7%	11%	0	8%	0
$301-$400	33%	8%	32%	3%	23%	1%	21%	0
$401-$500	8%	39%	17%	38%	35%	33%	38%	22%
Over $500	4%	44%	4%	46%	5%	64%	6%	78%

Source: A random sample based on calendar years by the Department of Income Maintenance of 3 percent of the active caseload in the 23 largest towns in Connecticut.

SUBSIDIZED ADOPTION PROGRAM

Program purpose: Financial and medical subsidies are available to adoptive parents to facilitate adoption of children with special needs under the care of the Department of Children and Youth Services (DCYS) or a Connecticut licensed child-placement agency.

Administering agency: Department of Children and Youth Services

Statutory authority: C.G.S. Sec. 17a-117 and Title IV-E of the Social Security Act

Federal reimbursement: The federal matching rate for the adoption assistance payments is based on each state's Medicaid matching rate (which ranges from 50 percent to 83 percent depending on state per capita income). In Connecticut, the federal match is 50 percent. States may also claim open-ended federal matching for the cost of administering the program (50 percent) and for training both staff and adoptive parents (75 percent).

Federal requirements: The federal adoption assistance program is required of states that participate in AFDC (which all states do).

State requirements: State-funded financial and medical subsidies are available to adoptive parents of children who are ineligible for Title IV-E (AFDC or SSI eligible) but who meet the definition of a special needs child. The adoption assistance program for non-Title IV-E children is operated and funded entirely at state option.

Program description: There are two programs offered in Connecticut:

- federal adoption assistance program - helps states support the adoption of Title IV-E (AFDC- or SSI- eligible) children with special needs by providing recurring (usually monthly) federally matched adoption assistance payments and matching funds for states that reimburse the nonrecurring (one-time) adoption expenses of special needs children regardless of AFDC or SSI eligibility; and

- state funded assistance program - for children who are not Title IV-E eligible.

Redetermination: DCYS must annually review the continued need for and the amount of the subsidies for all children receiving subsidies.

Eligibility for other federally funded programs: If designated as Title IV-E eligible, which means the child is AFDC or SSI eligible, the child is automatically eligible for Medicaid, whether or not assistance payments are being made.

State caseload for FY 92:

Title IV-E Eligible Children - 661
Non IV-E Eligible Children - 1,579
Total Children Subsidized - 2,240

The program review committee was unable to obtain an exact number of children not eligible for the adoption assistance program under Title IV-E because DCYS's computer system does not provide an unduplicated count of these children. According to the department, the figure above overrepresents the number of children not IV-E eligible by approximately 10 percent. The figure presented for Title IV-E eligible children is accurate.

Total program expenditures for FY 92:

Federal Adoption Assistance Program:

Federal Share - $1,912,895
State Share - $1,912,895
Total - $3,825,790

State Funded Adoption Assistance Program:

Total - $6,384,636

Federal and state eligibility criteria: In order to be eligible for adoption assistance under either the federal IV-E or state-funded program, a child must be a ward of the commissioner of DCYS, or is to be placed by a licensed Connecticut child-placement agency. In addition, parental rights must have been terminated. Third, one or more of the following conditions needs to exist in order for the child to be designated as having special needs:

- is a member of a minority race;
- has a physical or mental disability or serious emotional maladjustments;
- is over the age of eight;
- is a member of a sibling group that includes two or more children who should be, or remain, in the same adoptive home for whom no other resources consistent with the best interest of the child are available;
- has a recognized high risk of physical or mental disability; or
- has established significant emotional ties with the prospective adoptive parents while in their care as a foster child.

In addition to the above conditions, other criteria that may be used in determining whether a child is difficult to place include: the number of foster placements; the length of time in foster care; and whether previous efforts have been made to secure an adoptive placement without using the subsidized adoption program. However, both programs require that reasonable efforts have been made to place the child with adoptive parents without providing a financial subsidy.

The department was unable to provide the program review committee with a numerical breakdown of the actual reasons for which children are designated as having special needs. According to the department, this information is not automated but is part of each child's individual casefile.

Financial subsidies: There are two types of financial subsidies provided:

- *Nonrecurring expense subsidy* - Reimbursement is available for families adopting special needs children for adoption-related expenses in the form of a lump sum payment. Federal matching funds are available for the one-time adoption expenses of **all** children with special needs whether or not a child is eligible for AFDC or SSI payments;

  The federal government allows states to reimburse adoptive parents up to $2,000 for adoption expenses. However, Connecticut limits reimbursement up to a maximum of $750. Table III-17 shows total expenditures for nonrecurring adoption expenses, before federal reimbursement, for Connecticut over the last three years.

Table III-17. Reimbursement of Nonrecurring Expense Subsidy in Connecticut.

Fiscal Year	Number of Payments	Amount
FY 90	23	$7,385
FY 91	26	$8,560
FY 92	52	$18,481

- *Periodic subsidy* - recurring post-adoptive payment, usually paid monthly. For Title IV-E children, federal matching funds are provided; for children not eligible for Title IV-E, the subsidy is solely state funded.

Periodic subsidy amount. The amount of the periodic subsidy is based on the needs of the child and the level of care required. There are no income eligibility limits for prospective adoptive parents to meet for the subsidy program. However, income that is available to an adoptive child (social security, veteran's benefits, etc.) must be considered when determining the subsidy amount. In prior years, DCYS staff determined the subsidy amount according to a 16-tier rate schedule that was based on the age of a child and the child's special needs. Beginning in FY 93, the department will calculate the subsidy using one of three base rates, ranging from $497 for children 0 through 5 years old, to $572 for children 12 years old and over. The base rate may be adjusted up to $250 per month on a case-by-case basis, to meet the special needs of a child, within guidelines issued by the state.

Medical subsidy: Title IV-E children, as mentioned above, are automatically eligible for Medicaid. Under federal law, IV-E eligible adoption assistance children who move across state lines continue to be eligible for Title XIX in their new state of residence. However, if a needed Medicaid service specified in the adoption assistance agreement is not available under the Medicaid scope of services in the new state of residence, the state making the original adoption assistance payment remains financially responsible for providing the specified service.

In addition, Connecticut funds two medical programs for which no federally monies are recovered. These are:

- *Connecticut Medical Subsidy* - Children not eligible under Title IV-E and, therefore, not eligible for Medicaid under federal guidelines are provided comparable medical services through a state-funded medical program. However, only those medical services approved within the Medicaid program are covered. Any medical benefits provided prior to the final approval of the adoption shall continue as long as the child qualifies as a dependent of the adoptive parents.

- *Connecticut Medical Expense Subsidy* - Children who receive SSI benefits and are Medicaid recipients are eligible for a 100 percent medical expense subsidy. This is a state-funded program that provides additional medical coverage not allowed under the Medicaid scope of services. Decisions are made on a case-by-case basis and relate to the special medical needs of the child. Request for this subsidy must be initiated by a parent and may be applied for prior to or subsequent to the adoption. The subsidy is based on a determination during the adoption process or subsequent to the adoption that a specific condition existed prior to or reoccurred after the adoption and requires current medical care. To be eligible a child must be:

- blind;
- physically disabled;

- mentally impaired;
- seriously emotionally maladjusted; or
- a recognized high risk for physical or mental disability.

Eligibility for the medical expense subsidy is until the age of 21.

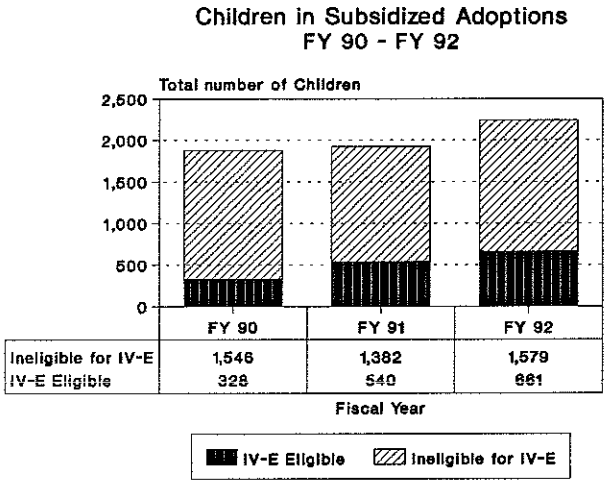
Termination of subsidy: Eligibility for the financial subsidy either under Title IV-E or the state-funded program terminates when any one of the following occur:

- child reaches 18 years old (no longer eligible for medical subsidy, but is still eligible for medical subsidy at state option until 21 years old);
- parents are no longer legally responsible for support of child;
- child is no longer receiving any support from the adoptive parents;
- upon conclusion of the terms of the subsidy agreement;
- adoptive parents request termination of the subsidy agreement;
- child dies;
- parents die; or
- parents fail to participate in the annual review process for adoption assistance.

Caseload and Expenditure Data

Figure III-24 presents the number of Title IV-E and non-IV-E eligible children in subsidized adoption from FY 90 to FY 92. As the figure shows, the number of children who have been designated as IV-E eligible has more than doubled over the three year period, while there has been only a slight increase in children who are not Title IV-E eligible. Overall, there has been a 20 percent increase in the total number of children in the subsidized adoption program. In addition, in FY 92, 71 percent of the children in subsidized adoptions were not eligible for federal matching funds. In FY 90, 83 percent were ineligible.

Figure III-24.

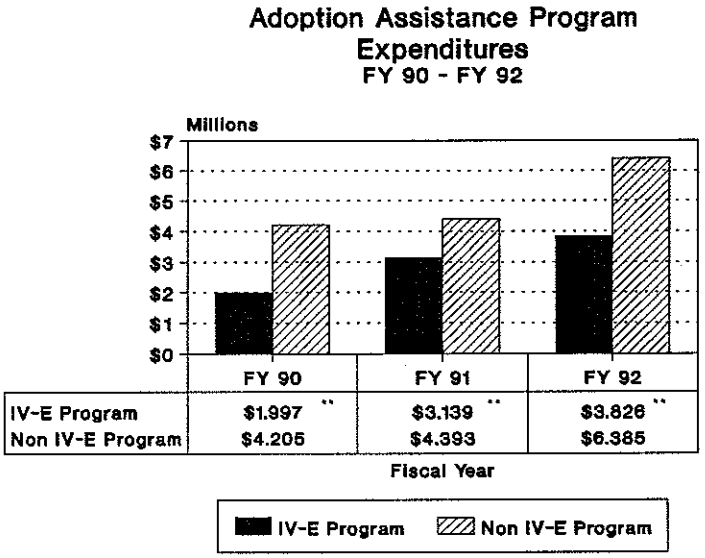


Source: DCYS

As mentioned previously, the DCYS estimates the number of children designated as Title IV-E ineligible is overrepresented by approximately 10 percent because of the format in which data are stored in the department's computer system.

Figure III-25 compares the expenditures for the Adoption Assistance Program that receives federal matching funds to those of the state-funded only program. As the figure shows, a total of $6,384,636 was spent on the state adoption assistance program in FY 92. This represents a 52 percent increase in state expenditures during the three years examined. Expenditures for the Adoption Assistance program were $3,825,790 (before 50 percent federal reimbursement) in FY 92, a 92 percent increase from FY 90. In addition, children not eligible for Title IV-E continue to account for the majority of total expenditures on adoption assistance, accounting for 63 percent of monies expended in FY 92.

Figure III-25.



SCHOOL NUTRITION PROGRAMS

Purpose: To offer meals to all children in schools and to provide those meals free or at reduced prices for children of low-income families.

Administering agency: State Department of Education, Office of Child Nutrition

Statutory authorization: C.G.S. Sections 10-215, 10-215a through 10-215d, and 10-266w, Federal National School Lunch Act (as amended) U.S.C. 1751 et seq., and Federal Child Nutrition Act (as amended) U.S.C. 1772, 1773, and 1779.

Eligibility criteria: Children whose family's gross income is below 130 percent of the federal poverty level for families of that size are eligible for free meals, and those whose families are below 185 percent of the poverty level are eligible for reduced-price meals. In order to be eligible, the annual gross income for a family of three cannot exceed $14,482 to receive free meals and $20,609 for reduced prices.

Participation rate: There are no federal requirements that states participate, or that school districts within a state offer the program. All public and private schools of high school grade or below that provide meals meeting the nutrition guidelines are eligible to participate. School districts choose whether or not they will participate, but once a district participates, it must comply with the administrative, fiscal, and nutritional guidelines of the program. Public Act 91-7, passed during the 1991 special legislative session, specified that, starting in January 1992, any school district in which any elementary school has 80 percent of its students eligible for free or reduced lunches is required to provide breakfasts at those schools.

Sites: In Connecticut, 869 schools offer lunches, while 134 of those also offer breakfasts. In addition, 264 other schools that do not provide meals do have a milk program. Only six school disricts in the state have schools that do not participate in any aspect of the School Nutrition programs. Of the schools participating, 253 are considered severe-need schools, which means that greater than a certain percentage of meals served are free or at a reduced price; these schools receive a higher reimbursement rate.

Reimbursement rates: All meals served at school sites are subsidized by federal and state government to some degree. There are two reimbursement rates, one for regular sites, and a higher rate for sites considered in severe need. For the school lunch program in severe need is defined as 60 percent of the meals served in a district are free or reduced-price, and for the school breakfast program, a severe-need school is one where 40 percent of the meals are free or reduced-price. The two reimbursement rates are provided in Tables III-18 and III-19.

There are federal requirements that impose a funding floor for states. They must contribute at least 30 percent of the amount of the federal reimbursement allowed for all meals (but not the free or reduced-price) served under the School Lunch Program for the school year

1981-82. The milk program is also subsidized, paying the full cost per serving for those children who meet the income guidelines, and subsidized at $.11 per serving for those children who pay. There is no federal requirement for state matching under the School Breakfast Program. In Connecticut, those school districts containing at least one severe need school are eligible to apply for state grants that help them provide breakfasts to children at these schools.

Table III-18. Reimbursement for School Breakfast 1991-92 School Year.	
Regular Sites	
Paid Breakfast (for students who pay full price)	$.19
Reduced-Price Breakfast (student cannot be charged more than $.30)	$.63
Free Breakfast	$.93
Severe Need Sites	
Reduced-Price Breakfast	$.80
Free Breakfast	$1.10
Sources of Data: Catalog of Federal Domestic Assistance Programs and CRS Report to Congress on Cash and Non-cash Assistance	

Table III-19. Reimbursement Rates for School Lunch Program 1991-92 School Year.	
Regular Sites	
Paid Lunch (For those students who pay full price)	$.16 for all lunches plus the amounts below
Reduced Lunch (Student cannot be charged more than $.40)	$1.10
Free Lunch	$1.50
Severe Need Sites	
All Lunches reimbursed an additional	$.02

The federal contribution for the state's program is distributed quarterly based on estimates of prior usage, but schools and the state Department of Education must file monthly reports on program operation in order to claim the funds. Federal reimbursement rates for the programs are shown in Tables III-18 and III-19. The rates are adjusted annually to reflect changes in the CPI for food in schools and institutions.

Benefit level: Schools may charge whatever they want for meals, as long as the charges do not result in a profit. Assuming that the regular reimbursement rate is what is actually charged for breakfast and lunch, and that a student participates in the school lunch program every school day, the value of the free lunch program for a full school year (180 days) equals $270, while the breakfast program for a full year equals $167. Thus, the value of the two meals for a full school year is $437. The value to the recipient is the meals themselves; they cannot be exchanged for cash or another type of assistance.

Eligibility determination: The determination of whether a child is eligible for reduced or free meals is made by the local school district. Documentation concerning the family income must be provided to the school or the district, and schools must keep the records for three years. Audits are conducted annually of those school districts receiving $100,000 or more.

Children whose families are receiving AFDC or Food Stamps are automatically eligible for the program. In Connecticut, the Departments of Education and Income Maintenance have initiated a program whereby DIM will issue letters automatically certifying those children eligible for the program. This program is planned to be operational by September 1992.

There is no income limit for those children who pay for meals, but for which there is the small reimbursement rate.

Program Activity and Expenditures

Children eligible: According to Department of Education figures, about 100,000 children were eligible for the free or reduced meals or milk during the 1991-92 school year. As Table III-20 indicates, that is about 21 percent of the 473,069 public school population, and a similar percentage of the vocational-technical school enrollment. It is important to note that the number of eligible children may be low for a couple of reasons. First, included in the table is the number of those whose families documented they met the income eligibility requirements, which is probably less than the number who actually would qualify for the program. Second, some schools do not participate in the program, and thus any eligible children at those sites would not be counted. The certification program that begins in September 1992 may increase the number of children eligible by easing the method for documenting eligibility.

Meals served: During federal fiscal year 1990-91 -- the last year for which complete activity data are available -- a total of about 46 million meals were served or about 255,555 every school day. Included in that number are those meals children paid for, those that were free, and those provided at a reduced price. Table III-21 presents the most recent data available on the number

of free and reduced-price meals served. In FFY 91, almost 18.2 million of the total 46 million meals (39 percent) were free or at reduced prices.

Table III-20. Number of Children Eligible for Free or Reduced-Price Meals, 1991-92 School Year.

	Student Enrollment	# Eligible for Free Lunch	# Eligible for Reduced Price	# Eligible for Free Milk	Total Eligible as % of Enrollment
Public Schools	473,069	77,920	18,592	2,604	20.9
Private Schools	67,630	545	313	387	1.8
Vocational Technical Schools	11,013	1,799	693	0	22.6
Total	551,712	80,264	19,598	2,991	18.6

Source of Data: Department of Education, Child Nutrition Programs Division, and Research Division

Table III-21. Numbers of Free and Reduced-Price Meals Served, FFY 89 -- FFY 92 (through June of 92).

	FFY 89-90	FFY 90-91	FFY 91-92 (through 6/92)
Free Lunch	10,927,379	12,266,481	11,574,117
Reduced-Price Lunch	1,972,027	2,013,093	2,127,234
Free Breakfast	2,034,769	3,666,698	3,683,586
Reduced-Price Breakfast	215,319	230,933	257,168
Totals	15,149,494	18,177,205	17,642,105

Source of Data: Department of Education, Child Nutrition Programs Division

Table III-22. Expenditures for Connecticut's School Nutrition Programs State FY 87 -- FY 91 ($000).

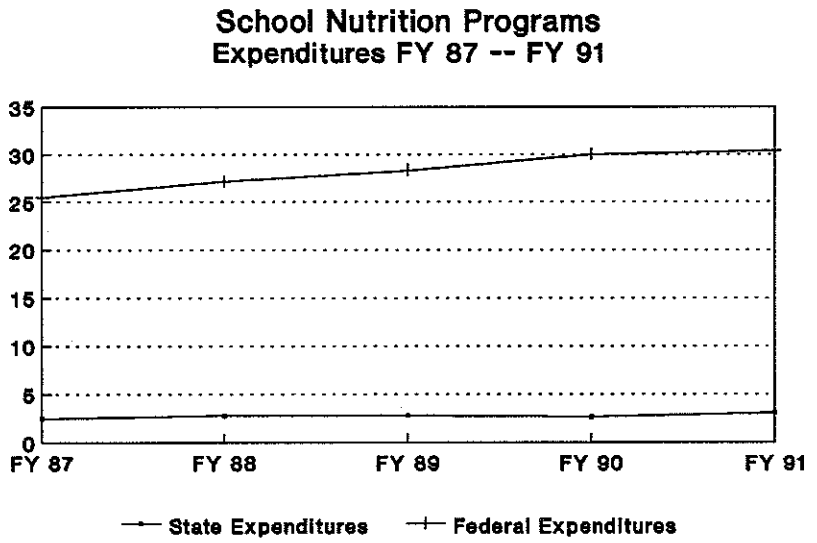
State Expenditures					
	FY 87	FY 88	FY 89	FY 90	FY 91
Nutrition Programs	2,220	2,220	2,193	2,175	2,354
School Breakfast	177	361	488	506	594
Administ. Costs	107	96	137	131	149
Total (State)	$2,504	$2,677	$2,818	$2,812	$3,097
Federal Expenditures					
	FY 87	FY 88	FY 89	FY 90	FY 91
School Breakfast	1,107	1,626	2,844	3,262	3,831
School Lunch	20,887	21,065	21,633	22,380	24,599
Milk Program	465	613	591	619	652
Other Nutritional Programs	6,150	7,908	7,812	9,790	10,140
Administ. Costs	510	482	431	502	594
Total (Federal)	$29,119	$31,694	$33,311	$36,553	$39,816

Source: Governor's Budgets and Department of Education Data

Expenditures: Table III-22 presents both the state and federal expenditures for the School Nutrition programs since FY 87. The state's expenditures have grown from approximately $2.5 million in FY 87 to slightly over $3 million in FY 91. But the state's expenditures are small compared to the federal contributions to the programs -- almost $40 million in FY 91.

Figure III-26 illustrates the expenditures for the same FY 87 to FY 91 period, and shows that the support for the school nutrition program is clearly more federal than state.

Figure III-26.



Governor's Budgets and DoED Data
Fed. Expenditures for School Sites Only,
Excludes Funding for other Nutrn. Prgms

CONNECTICUT PHARMACEUTICAL ASSISTANCE CONTRACT TO THE ELDERLY AND DISABLED (ConnPACE)

Program purpose: To reduce the burden of health care costs for low-income elderly and disabled persons by assisting them with payment for their prescription drugs.

Administering agency: Department on Aging

Statutory authority: C.G.S. Sections 17a-340 through 17a-359

Federal reimbursement: The state receives no federal reimbursement for this program.

Federal requirements: There are no federal requirements. This program is funded solely by the state General Fund.

Recipients: Elderly or persons with disabilities with limited incomes.

State caseload: 53,390 individuals as of June 30, 1992
946,626 paid claims (FY 92)

Average cost per prescription for FY 92: $29.75

Total expenditures: $28,379,879 (FY 92)

Eligibility criteria: To be eligible for participation in the ConnPACE program, an individual must:

- be a resident of the state for 6 months;
- meet income limits of:
  - $13,800 (single)
  - $16,600 (married);
- be 65 years old or older, or a disabled person over 18 years old and receiving benefits under the Social Security Disability Program (Title 2) or Supplemental Security Income Program (Title 16); and
- may not be enrolled in Medicaid or have prescription drug coverage that pays a portion or all of each prescription purchased.

No asset limit is applied when determining eligibility. Redetermination for continued eligibility is annually performed by the department. Income limits may be increased by the commissioner of aging to reflect the cost-of-living increase in Social Security.

Cost-sharing requirements: Eligible recipients are required to:

- pay a one-time $15 registration fee; and
- co-pay $10.00 per prescription.

Covered drugs: ConnPACE covers all prescription drugs, as well as insulin, insulin syringes and needles, with the following exceptions:

- drugs for cosmetic purposes;
- experimental drugs;
- drugs that the FDA has determined not to be effective;
- antihistamines;
- contraceptives;
- cough preparations;
- diet pills;
- multivitamin combinations; and
- smoking cessation gum.

Manufacturer rebate program: Public Act 91-8 required drug manufacturers to participate in a department rebate program in order to have their pharmaceutical products covered by ConnPACE. The program was effective July 1, 1991, and required manufacturers to rebate 11 percent of the average manufacturer's price back to the state.. Manufacturers who would not enter into the Rebate Agreement had their products discontinued from coverage in February 1992. The total rebate amount received in FY 92 was $1,787,428.

Program history: ConnPace, created by Public Act 85-573, established a 15-month pilot program to assist low-income elderly persons pay prescription costs. Since its origination, ConnPACE has undergone several changes, most affecting eligibility criteria.

The program became operational on April 1, 1986, and had the following requirements:

- 50 percent co-pay;
- income limits of:
  -$9,000 (single)
  -$12,000 (married); and
- $15 enrollment fee.

ConnPACE was amended by Public Act 87-3 and became a permanent program. The act was amended to reflect the following changes:

- $4.00 co-pay;
- income limits raised to:
  -$13,300 (single)
  -$16,000 (married);

- extended coverage to persons with disabilities over 18 years old; and
- eliminated the enrollment fee.

Special Act 90-18 modified ConnPACE by:

- increasing participants' co-payment to $6.00.

Public Act 91-8 of the June Special Session:

- increased the prescription co-payment to $10.00; and
- re-established a $15.00 enrollment fee.

In the last legislative session, eligibility for the program was further restricted through Public Act 92-196, which discontinued coverage for individuals who have Medicaid or full or partial insurance coverage for prescription drugs once a deductible amount is met.

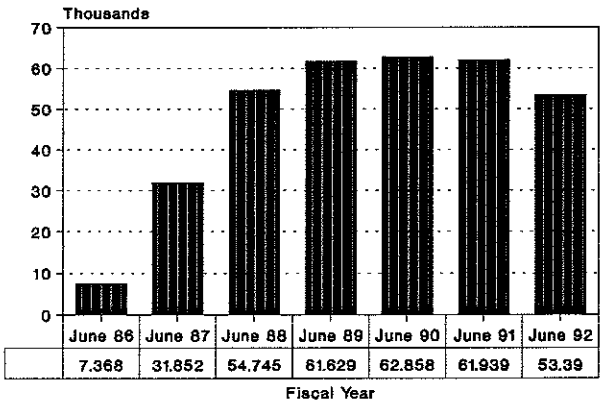
Program Activity and Expenditures

Figure III-27 shows the growth in the ConnPACE program since its creation in April of 1986. As the figure shows, the greatest increase in program recipients occurred in the first three years of the program's operation. The number of recipients remained stable from June of 1989 through June of 1991. Over the past year, there has been a decline of 8,549 individuals enrolled in the program. Possible reasons for the decrease in enrollment include:

- ConnPACE income limits have not increased to reflect cost of living adjustments (COLAs) from Social Security;
- the increase in the co-pay to $10; and
- the reestablishment of a $15 enrollment fee.

Figure III-27.

ConnPACE Enrollment
June 30, 1986** - June 30, 1992

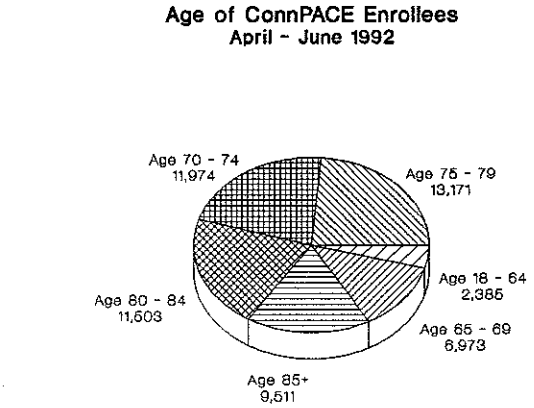


** April 1 - June 30, 1986.

Source: ConnPACE Quart. Report

Figure III-28 shows the age ranges of the individuals enrolled in ConnPACE. The smallest group are those receiving ConnPACE because they meet the definition of disabled and are between 18 and 64 years old.

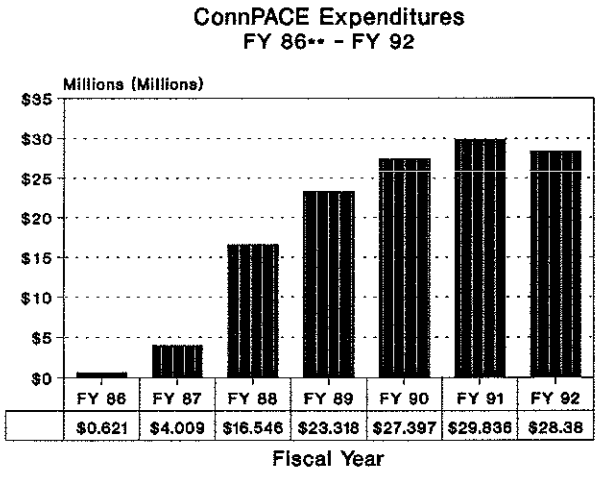
Figure III-28.



Source: ConnPACE Quart. Report

Figure III-29 shows program expenditures for FY 86 through FY 92. Even discounting the first year (1986), in which ConnPACE was only a pilot program, expenditures between FY 87 and FY 92 increased 607.9 percent. Most of the increase in expenditures, as shown in the figure, occurred in the first four years of program operation. Total expenditures for the program in FY 92 were $28,379,879, a decrease of nearly 5 percent from the prior year. One likely reason for the decrease in expenditures is the decline in individuals participating in FY 92.

Figure III-29.



** April 30 - June 1, 1986.

Source of data: ConnPace Quart. Report

Although total expenditures have declined in the past year, average prescription costs have increased. This is shown in Figure III-30, which presents the average price per prescription by quarter since FY 89. This would indicate the number of prescriptions have declined at a greater rate than the decrease in total expenditures.

The decrease in the number of prescriptions is likely related to restrictions that have been placed on the program, such as the change in the co-pay requirement, and the overall decline in enrollees. This decrease is illustrated in Figure III-31 which shows by quarter, the average number of prescriptions per enrollee from FY 89 through FY 92

Table III-23 presents information that describes the program components, for the eight other states that offer a prescription program for the elderly. This table was obtained from the Commission to Study the Management of State Government's (Thomas Commission) study of the Department on Aging.

Figure III-30.

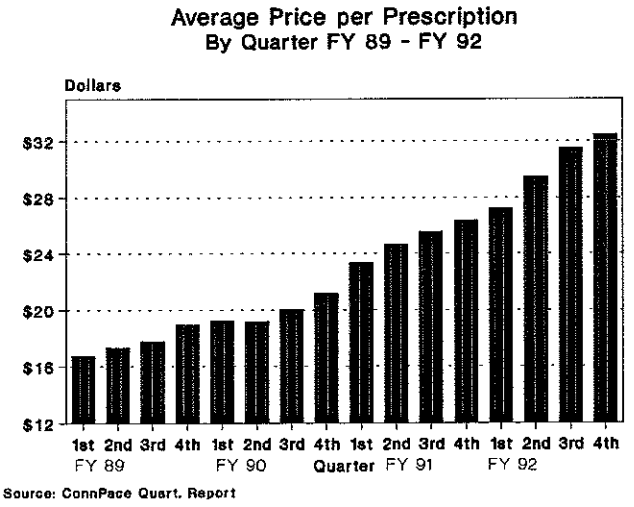


Figure III-31.

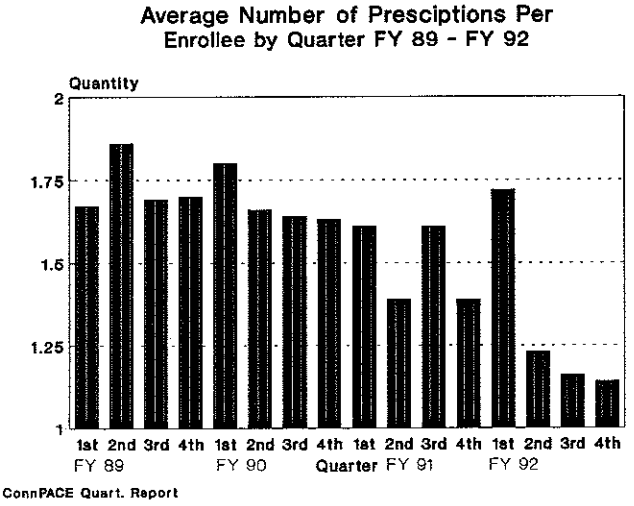


Table III-23. Prescription Programs for the Elderly.

	CT	DE	IL	ME	MD	NJ	NY	PA	RI
Agency Responsible	Dept. of Aging	Nemoura Health Clinic	Dept. of Revenue	Medicaid Agency	Dept. of Health & Mental Hygeine	Dept. of Human Svc	Elderly Pharm. Ins. Coverage Program	Dept. of Aging	Dept. of Elderly Affairs
Age Requirement	65 18 if disabled	65	62 55 if disabled	All Citizens	65 18 if disabled	65	65	65	
Income Limit	$13,800 Single $16,600 Couple	$8,500 Single $12,000 Couple	$14,000 Household	$8,000 Single $10,000 Couple	$7,050 Single $7,650 Couple	$13,650 Single $16,750 Couple	$9,000 - $15,000 $12,000-$20,000 (Two Tier)	$12,000 Single $15,000 Couple	$12,000 Single $15,000 Couple
Asset Test	None	None	None		$3,700	None	None	None	None
Enrollment	68,000	14,000		14,000	15,500	210,000	82,000	394,000	16,800
Budget	$30 Million	No State Funds		$3 Million	$10.1 Million	$133 Million	$40 Million	$223 Million	$3 Million
State Resident	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Co-pay	$6/Rx	10% of Rx	None	$2/Rx	$1.50/Rx	$2/Rx	$5/Rx $30$15/Higher Tier	$4/Rx	40% of Rx
Application Fee	None	None	$80 Property Tax Rebate	None	None	None	$20-76 per year $268-414/Higher Tier	None	None
Drug Coverage	All prescription drugs insulin with syringes and needles	All prescription drugs	Cardio-vascular, arthritis, diabetes, high blood pressure	Diabetes, heart, high blood pressure, arthritis, chronic lung	All drugs including cough syrup, insulin with syringes & needles, and coated aspirin	All prescription drugs	All prescription drugs including insulin with needles and syringes	All prescription drugs including insulin with needles and syringes	Cardio-vascular, hypertension, cancer diabetes, glaucoma, anti-coagulants, parkinsons, & cholesterol
Generic Drugs	must use unless specified by doctor		generic covered, patient must pay extra for brand name	must use unless doctor justifies	must use unless brand specified by doctor	must use unless specified by doctor		must use unless specified by doctor	must use unless specified by doctor
Program Start	1986			1983	1979	1976	1987	1984	

Source: Commission to Study the Management of State Government's (Thomas Commission): MGT of America, Inc., study of the Connecticut Department on Aging.

HIGHER EDUCATION -- TUITION WAIVERS

Purpose: To waive the payment of tuition for certain statutorily specified categories of persons at the state's public higher education facilities.

Administering agency: Each higher education constituent unit administers its own tuition waiver program.

Statutory authority: No federal requirements. The following sections of the Connecticut General Statutes authorize the program:

- Section 10a-105(d) for the University of Connecticut;
- Section 10a-99 for the Connecticut State Universities;
- Section 10a-77(d) for the Community Colleges; and
- Section 10a-83(d) for the Regional and Technical Colleges;

Federal requirement: None

Federal reimbursement: None

Eligibility: The groups listed in Table III-24 are eligible because they belong to a category of persons statutorily deemed eligible for the tuition waiver program. There are no income or asset tests that individuals must meet. [16]

Scope of waiver: Under the statutory tuition waiver program only the cost of tuition is waived; other fees such as room and board, and student fees still apply.

Total cost of waiver program -- FY 92:

University of Connecticut =	$6,451,736
Connecticut State University =	$ 659,358
Community/Technical Colleges =	$1,156,047
TOTAL	$8,267,141

[16] In addition to those categories for which tuition is statutorily required to be waived, employees of the institutions, and their dependents are eligible for tuition waivers through collective bargaining contracts.

Funding: The funding for the tuition waiver programs comes from the Tuition Fund, the revenues colleceted from students' tuition fees. If the tuition waiver amounts for the first four categories in Table III-24 exceed a percentage of the funds, the State is statutorily required to appropriate reimbursement for the exceeded amount. At the University of Connecticut and Connecticut State University if the amounts exceed 2.5 percent of the fund, the state must reimburse the fund. At the Regional Community and Technical Colleges, if the waiver amounts exceed 5 percent of the total fund, reimbursement is due.

Table III-24. Tuition Waiver Program: Eligible Categories and Constituent Units.

	University of Connecticut	Connecticut State University	Community Colleges	Regional and Technical Colleges
Senior Citizen: Must be at least 62 years of age and a resident of Connecticut	Yes, but must be in degree-granting program, or if space is left after registration	Yes, but must be in a degree-granting program, or if space is left after registration	Yes, if space is left after registration	Yes, if space is available after registration
Veterans: Must be a CT resident and have served as statutorily specified	Yes	Yes	Yes	Yes
Active Army or National Guard: Must be member in good standing and a CT resident	Yes, but must be admitted to a degree-granting undergraduate program	Yes, but must be admitted to a degree-granting undergraduate program	Yes, but must be admitted to a degree-granting program	Yes, but must be admitted to a degree-granting program
Dependent Children of MIAs or POWs: CT members of Armed Forces who have been declared Missing in Action (MIA) or Prisoner of War (POW) as specified in statute	Yes	Yes	Yes	Yes
Graduate Assistants	Yes	No	No	No
Student at CT. Police Academy: Must be enrolled in certain courses	No	Yes	Yes	Yes

Program activity and costs: There were 8,417 tuition waivers granted to persons who belonged to groups statutorily required to receive those waivers. This number does not include waivers granted to employee's dependents who receive tuition waivers through contract provisions. The numbers of waivers are for two semesters and could cover the same individuals. Thus, the number of waivers is not identical to the number of persons who received them. The statistics on tuition waivers granted and the costs for the constituent units are provided in Table III-25.

Table III-25. Numbers of Tuition Waivers and Amounts by Groups and Constituent Unit, FY 91 -- FY 92.

	University of Connecticut		Connecticut State University		Community and Technical Colleges	
	Number Waived	$ Waived	Number Waived	$ Waived	Number Waived	$ Waived
Senior Citizen	9	$7,998	15	$13,075	2,043	$303,949
Veterans	167	$211,836	356	$250,043	1,739	$514,790
Children of MIAs/POWS	0	0	0	0	0	0
National Guard	318	$442,743	575	$258,516	921	$337,308
Graduate Assistants	2,274	$5,789,158	0	0	0	0
TOTAL	2,768	$6,451,735	946	$521,634	4,703	$1,156,047

Source: Data Provided by the Institutions

AMBULANCE TRANSPORTATION PROGRAM

Purpose: The Ambulance Transportation program pays for the transportation of intoxicated persons and alcoholism patients to treatment facilities or hospitals.

Administering agency: Connecticut Alcohol and Drug Abuse Commission

Statutory authority: C.G.S. Section 17a-635(6)

Federal requirements: None

Federal reimbursements: None

Eligible recipients: Intoxicated persons or alcoholism patients who require transportation to a treatment facility or hospital.

Ineligible recipients: Drug users and drug abuse patients.

State caseload: The total number of claims for FY 92 was 11,149.

Average cost per case: The average cost per claim for FY 92 was $114.

Total expenditures: FY 92 expenditures for the program were $1,267,716.

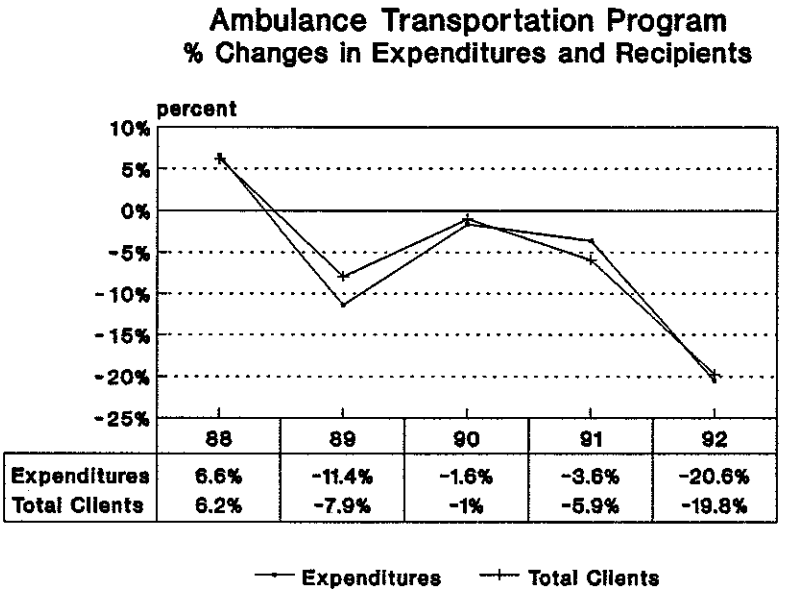
Program Description

Administration: CADAC reimburses ambulance companies for transporting intoxicated clients and alcoholism patients to treatment facilities or hospitals. An ambulance company will transport a client to a treatment facility or hospital and bill CADAC for transportation costs, if the company cannot be reimbursed by a town or the Department of Income Maintenance. CADAC is the payer of last resort for transported clients. Reimbursements are based on DIM transportation rates. If it can be determined from available information that a client is able to pay for his or her transportation, the Department of Administrative Services (DAS) will bill the client.

Caseload and expenditure trends: As Figure III-32 shows, the number of clients has declined since 1988 by an average of 5.7 percent per year. Total expenditures have also declined by an average of 6 percent per year. The average cost per claim continued to rise, however, by an average of 2 percent per year until FY 92 when it declined by 0.8 percent from the previous fiscal year. According to the Office of Fiscal Analysis, transportation to Hartford area hospitals

and to state treatment facilities account for 63 percent of all claims statewide. Table III-26 lists the total number of claims, average cost-per-claim, and total expenditures for the past five fiscal years.

Figure III-32.



Source: CADAC

Table III-26. Ambulance Transportation Program: Claims and Expenditures FY 88 - FY 92

Year	Number of Claims	Average Cost Per Claim	Total Expenditures
FY 88	17,826	$107	$1,900,883
FY 89	16,412	$108	$1,684,302
FY 90	14,773	$112	$1,656,712
FY 91	13,898	$115	$1,597,455
FY 92	11,149	$114	$1,267,716

Source: Connecticut Alcohol and Drug Abuse Commission

CHAPTER IV

COST OF BENEFITS ANALYSIS

At the initial stages of this study, the program review committee requested that the benefits clients on public assistance receive, and the costs of those goods and services, be included as part of the study scope. The study attempted to evaluate who receives these services and their costs; however, the services analyzed are not exhaustive, and there are several caveats attached to the results.

Methodology

As has been stated, programs and services used by public assistance populations are not located in one department; therefore, the data to assess client usage are not maintained on one system. Further, even when the data are kept by one department, the linkages between the computerized systems that pay bills and maintain records on the clients who use those services are weak. For example, state FY 92 expense data that indicate Medicaid usage by each of the various client populations are not available.

Limited by these data shortcomings, the committee identified the participation rate from the AFDC and State Supplement populations in seven other entitlement and public assistance programs: Medicaid; Food Stamps; School Lunch; Energy Assistance, Job Opportunities and Basic Skills program (JOBS); Supplemental Food Program for Women, Infants, and Children (WIC); and Housing. These participation rates and average costs are provided in Table IV-1. A discussion of how both were calculated is contained in Appendix E.

Most of the data used to conduct the analysis were received from the Department of Income Maintenance through its quality control reports issued to the federal government, information from the computerized Eligibility Management System (EMS) that handles client information, or the Medicaid Management Information System (MMIS) handling medical payments. Information on participation in the School Lunch program was based on the number of letters of certification that DIM sent to AFDC families to be used as eligibility verification, and the costs are calculated based on federal reimbursement rates.

However, not all data on the participation rate and average costs of the housing rental subsidy rates were available from the Department of Income Maintenance. To ascertain this, program review staff conducted a phone survey of all housing authorities in the state. Authority staff provided data on the number and costs of certificates, vouchers, and units subsidized through the Section 8 program, the number of public housing units managed by the authorities, as well as the rents charged for those units. However, in most authorities, the housing authority staff could only provide estimates on the number of Section 8 subsidies and public housing units being used by families or individuals on public assistance.

An analysis of the participation rates and the costs of service by programs received by the AFDC and state supplement populations is provided below. The costs are for the benefits themselves, and do not include costs of administering the programs. It is important to note that several of the programs (e.g., Food Stamps, Section 8 housing subsidies, and WIC) involve no state funds, but are entirely federally funded. In addition, with few exceptions (e.g., cash assistance, JOBS Special Benefits, and special need rental supplement), participation in any of these programs is not limited to AFDC clients. Other persons also may qualify for rental subsidies, Food Stamps, and Medicaid, depending on their income and expenses. Thus, caution should be used in reaching conclusions about the costs of these programs for public assistance clients.

Cost of Benefits For AFDC

One of the primary objectives of the committee's review was to analyze the standard of living families achieved through receipt of the benefits provided under the various entitlement programs. For reasons described above, this proved to be an impossible task. However, in an effort to give some measure of the relationship between the value of the benefits provided and the resulting economic status of families, the committee constructed a hypothetical model.

Data limitations compelled the committee to define the value of a benefit received as the average cost of the benefit provided. An important distinction between the two measures can be understood by realizing there may be a considerable monetary difference between the value a person places on being covered by a service (i.e., what the person would be willing to pay for the coverage) and the actual cost of the service.

The program review committee was unable to identify the exact number of services AFDC families receive because the department is unable to perform certain data crossmatches that would identify client overlap among programs. However, within each individual program, the department was able to provide the percentage of AFDC families (based on 55,039 cases for FY 92) receiving a specific service. Table IV-1 shows the number and percent of AFDC families receiving each service, and the average cost of the service. Most figures reflect FY 92 data, except for Medicaid in which FY 91 data were used.

The sum of the average costs of all benefit programs, except housing subsidies, that an AFDC family could be eligible for is presented in Figure IV-1. The figure is a hypothetical construct based on the average cost of each of the benefits listed. It is critical to note that the large majority of AFDC recipients would not be receiving all of the services in the figure. For example, a family with no school age children would not receive the school nutrition program. Second, it is highly unlikely that even those individuals eligible for all the services listed would receive the exact average cost of each service. Thus, the range of benefits a family may receive may be either considerably less or more than the average. Finally, the cost of housing subsidies is not included. When housing subsidies are included (see Figure IV-2), the total cost can increase significantly depending on the type of subsidy received.

Figure IV-2 presents the percent of families receiving either a housing subsidy or a special need rental supplement. The figure shows a tremendous difference in the average subsidy amount depending on the type of subsidy received. The biggest percentage (41 percent of AFDC families) receive an annual $600 special needs rental supplement. The average cost of providing housing for 11,558 families who hold either a Section 8 certificate or voucher, or a Rental Assistance Program (RAP) certificate, is $6,096 annually. This amounts to a $5,496 difference between the two subsidy types. Furthermore, the program review committee estimates, based on the survey, at least 7,155 (13 percent) AFDC families reside in public housing. But this number underrepresents AFDC families residing in public housing projects

Table IV-1. Number of Paid Cases and Average Cost by each Program For FY 92.

Program	Number of Paid AFDC Cases	Percent AFDC Families Receiving Services*	Average Annual Cost of Program Benefits per AFDC Family
AFDC Cash Assistance	55,039	100%	$6,840
Medicaid **	**	100%	$3,900
Food Stamps	48,434	88%	$2,004
School Nutrition	20,915	38%	$424
Energy	18,713	34%	$428
JOBS	7,151	13%	$1,398
WIC	n/a	n/a	$397
Housing: Section 8/RAP	11,443	21%	$6,096
Housing: Special Rent Supplement	22,800	41%	$600
Housing: Public	7,151***	13%	***

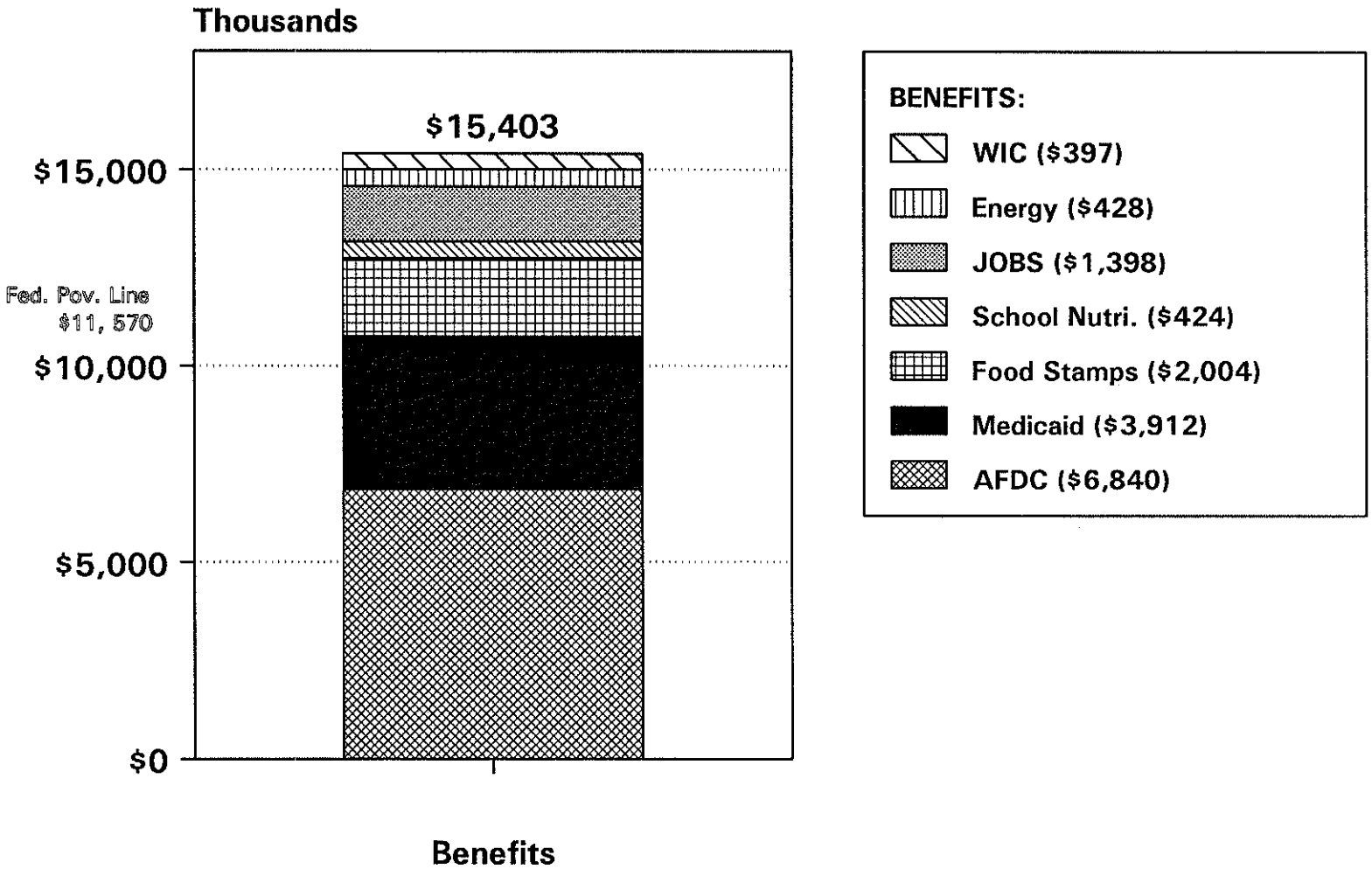
* The percentages shown in this column are not cumulative, but represent the percent of AFDC families receiving the service listed in the first column. It is important to note that due to data limitations, it is impossible to measure the extent of client overlap between the programs with less than a 100 percent participation.

** Medicaid data based on FY 91 figures of 40,149 paid cases. All other program data is based on FY 92 figures of 55,039 cases.

*** Number and percent of AFDC families living in public housing is underrepresented because committee staff did not survey nonprofit organizations and private management companies that also operate public housing projects.

Figure IV-1.

Average Cost of Benefits if Recipient of All Programs (Excluding Rental Subsidy)

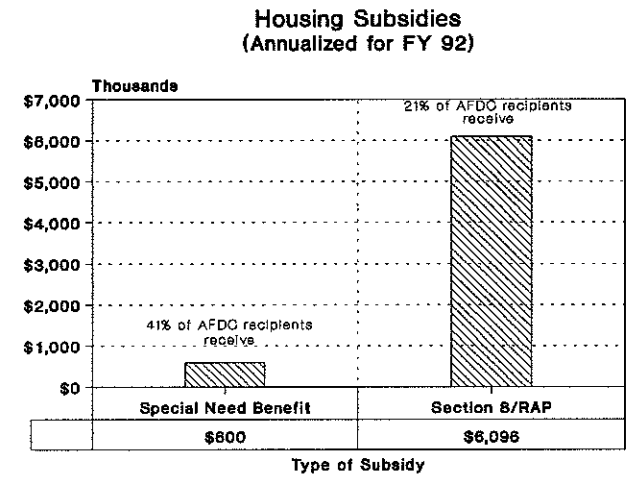


For a Family of Three in FY 92.

because nonprofit organizations and private management companies operating public housing projects were not surveyed by the committee. The remaining AFDC families (under 25 percent) live in private housing but do not receive any subsidy.

Theoretically, if the average expenditure for housing subsidies is added to the average cost of benefits listed in Figure IV-1, the cost of the benefit package, on average, would be $16,003 for families with a special need rental supplement. This figure would increase to $21,499 for families who possess either a Section 8 or RAP certificate or voucher.

Figure IV-2.



Source of Data: LPR&IC Analysis.

As a standard of living to compare the benefit to, the committee chose the federal poverty level, which was $11,570 for a family of three in FY 92. Figure IV-1 provides a rough estimate of how a family eligible for all the benefits provided compares to the federal poverty line, a widely accepted measure of a family's economic status.[17]

Cost of Benefits for State Supplement

There were 27,778 State Supplement recipients in Connecticut during FY 92 -- 9,242 aged, 160 blind, and 18,376 disabled. The costs of providing State Supplement benefits is largely based on the living situations of the clients, thus the following program review analysis is based on the type of residence of the client. The average annual benefit costs for State Supplement recipients were calculated separately for aged, blind, and disabled recipients residing in either DMR or nonDMR boarding homes, and for recipients not residing in boarding homes. The benefit amounts take into account the different services that State Supplement recipients may or

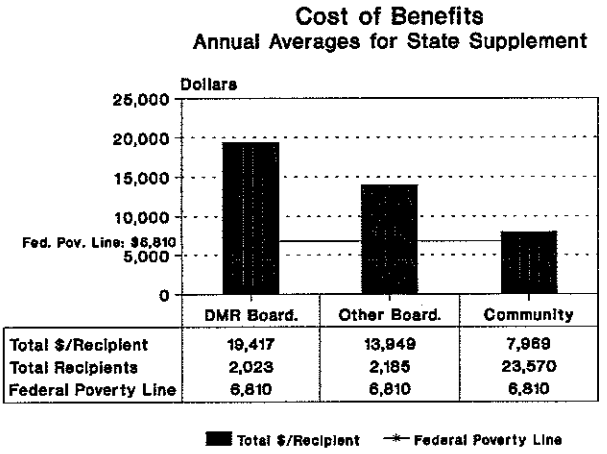
[17] It is important to note that the federal poverty level measure is under some scrutiny. Annual inflation adjustments are made to the poverty thresholds based on the official Consumer Price Index (CPI-U). Prior to 1983, the official CPI-U measured housing cost changes using the asset value of homes, which led to excessive growth in that index in the 1970s and early 1980s. Since 1983, a rental equivalence measure has been used. But because adjusting poverty thresholds for inflation is cumulative, a lower measure of inflation in the past results in a lower current indicator. Thus, had poverty thresholds been updated between 1967 and 1982 using the rental indicator, the current threshold would be approximately 8 percent lower. That would translate to a federal poverty level of $9,992 for a family of three, and would mean that fewer people would be classified below the poverty level.

may not be eligible to receive through other noncash assistance programs, like Medicaid, Food Stamps and Energy Assistance. For a detailed discussion of the number of State Supplement recipients participating in these programs and how the benefit levels were calculated see Appendix E.

However, additional income that a recipient may be eligible for (federal Supplemental Security Income (SSI), Social Security, Veteran's Benefits, private pension, or other source of income) is not included in the following analysis because there is no method to verify what income or incomes a recipient may be receiving in addition to their State Supplement benefit. However, about 18,500 recipients received an average SSI payment of $296 per month or $3,553 per year in FY 92.

Benefit cost comparisons. Figure IV-3 compares the total cost of benefits for recipients in DMR boarding homes, nonDMR boarding homes, and recipients living in other non-boarding home situations. The State Supplement benefit for each category is weighted by the number of recipients living in that situation. All three categories include the average weighted Medicaid benefit of $4,988 per year for all State Supplement recipients. The cost of benefits for community residents also contains the average weighted energy assistance benefit of $428 per year and the weighted average food stamp benefit of $310 per year for those who receive these services. Not all community residents received these, but these are the average costs for those who did. The latest federal poverty level for an individual ($6,810) is shown on the left side of the graph.

Figure IV-3.



The graph reveals that DMR boarding home recipients had the highest cost of benefits at $19,419 per year, while non-DMR boarding home recipients had an average cost of benefits of $13,949 per year, and community recipients had average cost of benefits of $7,969 per year. The boarding home benefits are due to the high cost of providing services to a recipient under these two living arrangements as compared to those provided to a recipient who has other living arrangements. The State Supplement benefit for a DMR boarding home recipient is almost 6 1/2 times the benefit for a community recipient. The DMR boarding home benefit is 2 1/2 times the benefit for a community recipient even after adding energy assistance and food stamps to the cost of benefits for a community recipient. All groups who receive these benefits are above the federal poverty level of $6,810 per year for an individual.

Community resident benefit costs. Table IV-2 lists the number of paid nonboarding home cases and the average costs for State Supplement cash assistance, Medicaid, Energy Assistance, Food Stamps, and Housing subsidies for this group. The table also lists the number of recipients participating in each program, the percentage of all nonboarding home cases receiving services, and the average annual cost per recipient for the nonboarding home cases. Most figures reflect FY 92 data, except for Medicaid in which FY 91 data were used.

Table IV-2. Paid NonBoarding Home Cases and Average Cost per Program.

Program	Number of Paid Non-Boarding Home Cases	Percent of Recipients Receiving Services	Average Cost of Providing Program Per Recipient
State Supplement Cash Assistance	23,570	100%	$2,243
Medicaid *	*	100%	$4,988
Energy Assistance	6,013	26%	$428
Food Stamps	13,065	48%	$310
Housing: Section 8/rap	2,066	9%	$5,651
Housing: Public	1,709**	7%	**

* Medicaid data based on FY 91 figures.

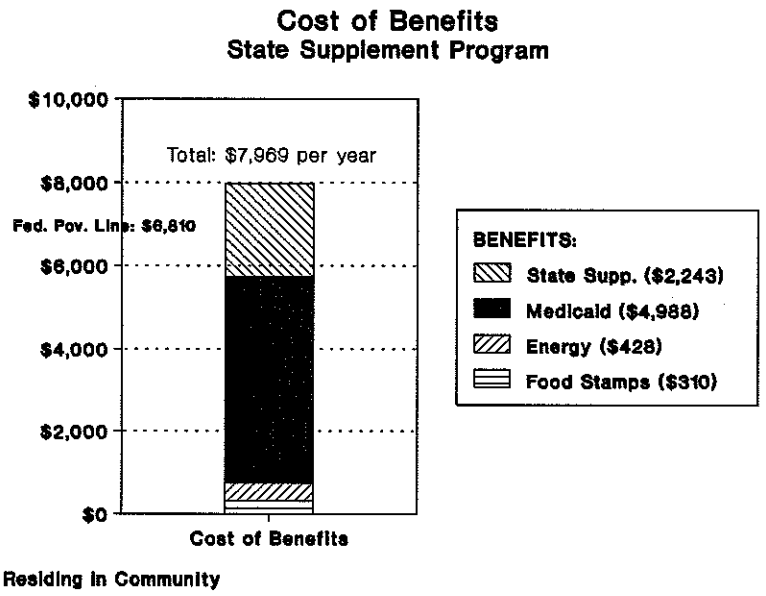
** Number and percent of State Supplement recipients living in public housing is underrepresented because committee staff did not survey nonprofit organizations and private management companies that also operate public housing projects.

Figure IV-4 displays the total cost of benefits for State Supplement recipients residing in the community. The benefit costs are separated by the weighted average State Supplement, Medicaid, energy assistance, and food stamp benefits for all community recipients. It is important to note that, just as with AFDC, not all State Supplement recipients living in the community received the food stamps and energy assistance.

If housing benefits are included in the benefit packages for non-boarding home recipients, their income is increased by an average of $5,651 per year for individuals who have either a Section 8 or RAP certificate or voucher. The overall income for a recipient would be $13,620 per year. However, it is estimated that only 2,066 State Supplement recipients, out of a total of 23,570 non-boarding home residents are receiving a housing subsidy under the Section 8 program or RAP programs. The program review committee estimates, based on the previously

mentioned housing survey, at least 1,709 State Supplement recipients (7 percent) reside in public housing. As with AFDC, this number underrepresents recipients residing in public housing projects because non-profit organizations and private management companies were not surveyed by committee staff.

Figure IV-4.



Aged, Blind, and Disabled Medicaid-Only Recipients

It is important to note that the Medicaid costs provided in the above analysis do not include any of the aged, blind, or disabled recipients that may be receiving Medicaid only (and no cash assistance), including those in long-term care (i.e., nursing homes). The total number of these Medicaid-only cases is 41,060, and about half of those cases (21,201) are persons in long-term care facilities. The total average cost for aged, blind, and disabled Medicaid-only cases was $16,489 for FY 91, the most recent year that such data were available. However, analysis performed by committee staff based on DIM data for June 1992, indicates the average annual Medicaid costs were $35,928 for individuals residing in long-term care facilities.

Medicaid recipients residing in long-term care facilities are ineligible for State Supplement cash payments, but they can receive a personal needs allowance of $30 per month under the federal Supplemental Security Income program. The state has no involvement in the payment of the personal needs allowance to these recipients.

CHAPTER V

FINDINGS AND RECOMMENDATIONS

The Legislative Program Review and Investigations Committee's findings and recommendations concerning entitlement programs are contained in this chapter. To a great extent the findings and recommendations focus on the deficiencies in the development, oversight, and performance monitoring of entitlement programs. The committee believes that information and communication among levels and branches of government about how programs are developed, by whom, and for what purpose are lacking. The committee believes that improved policy oversight is especially important with regard to the large federal-state programs, like AFDC and Medicaid, with great program complexities and federal funding mandates. A number of recommendations are made to improve the development and oversight of policies concerning entitlements. The committee also recommends that the legislature have greater control in the appropriations process regarding cash assistance programs and recommends a repeal of the statutorily required automatic cost-of-living increases for those programs.

Based on its review of entitlement programs, the committee also believes that increased emphasis should be placed on self-sufficiency of clients, including better prevention efforts, such as the development of a plan to prevent and reduce out-of-wedlock births. Also, the committee found that greater efforts are needed to collect and analyze data concerning welfare dependency so that policy can be developed to reduce long-term welfare dependency.

POLICY DEVELOPMENT AND POLICY OVERSIGHT

Policy development and implementation and oversight of policies is especially difficult where entitlement programs are concerned. Part of the problem is that entitlement programs are large, their results are intangible, the developers of the policies are spread among several levels and branches of government, and reasons for increasing costs are elusive and varied. In this section, the program review committee cites areas where the development and oversight of policies concerning entitlement programs are deficient and some ways in which the process can be improved.

Lack of Social Policy

Connecticut's social service system has evolved program by program over the decades to meet a wide breadth of needs, as illustrated by the several different recipient populations served by entitlement programs under review. Because of this incremental approach and because the client-base lacks homogeneity, goals tend to be articulated within but not across programs. Although the program review committee found policy goals related to specific programs referenced in different areas of the Connecticut General Statutes, there is no evidence of a clearly defined broad social policy extending across the human service system that would serve as an overall guide for decision-making.

One explanation for this lack of social policy is the effect of a strong federal presence in many of the entitlement programs. As a result, state policymakers may have given up much of their role in making and overseeing policy because of this federal control. Further adding to the lack of control is the difficulty in achieving a consensus on the scope of social services state government should provide to needy citizens.

The only institutionalized mechanism for establishing social service policies is the budget process. That process is complex with different actors often having conflicting purposes. For example, some legislators seek to control costs, while others want to increase the standard of living of persons perceived to be disadvantaged due to age, disability, income, or other special need. Persons with these needs, and those advocating on their behalf, also participate in the process, in pursuit of expanded benefits. Finally, agencies that administer social service programs often use the budget process to advocate for their clients and to ease their administrative burden.

Thus, when the opportunity to obtain federal financing occurs, all groups often welcome the influx of those funds without weighing the impact of federal involvement. Typically, once states accept federal funds the result is loss of state programmatic and fiscal control. Thus, pursuing policies based on maximizing federal aid can have negative consequences.

The lack of an overall policy also contributes to the inequities in the system by providing different populations dissimilar levels of services. Examples of these inequities are cited in the Chapter IV. Further, the programs foster inequities with their different eligibility criteria, different income and asset tests, and varied benefit levels.

Another problem created by the absence of an overall social policy arises in the face of opposing policy options. Without established priorities, there is no clear path for choosing one option over another, nor any clear reasons why some options are selected over others.

The lack of an overall social policy has become apparent to recent task forces as they look at various aspects of the state's human service system. As a result of Public Act 92-16, May 1992 Special Session, the Welfare Reform Task Force was convened in the fall of 1992. The members first found it necessary to establish principles to guide the work on welfare reform and set up a framework for discussion of the issues surrounding their mandate.

In 1991, the Commission to Effect Government Reorganization Task Force on Social Services and Services to Persons with Disabilities noted the fragmentation of services among populations and lack of policy coordination among agencies. The task force reorganized 13 human services agencies into 4. In its work, the task force also developed a mission for the health and human service system, which was later adopted by the full commission. However, only a small piece of it, which is "to promote the well-being of the state's citizens" was included in the legislation and subsequently passed by the General Assembly. Efforts to develop a vision, mission, and policies for the new Department of Social Services are currently being discussed.

The program review committee believes the absence of a stated social policy for Connecticut leads to several problems in planning for programs and analyzing program results. Without consensus on a broad policy purpose, there is no framework for policymakers to decide on program options. The lack of a broad policy consensus exacerbates the intensity of debates of how resources should be allocated among the needy populations, with policy choices then decided by the groups with the most political influence.

Therefore, the program review committee recommends that the reorganization team be given the opportunity to develop a broad social policy, and submit it to the legislature for action. If that group does not adopt one, the legislature should develop one.

Oversight of Entitlement Programs

Having an overall state policy in which to assess programs is an important step toward an informed decision-making process. But even if such a statement were in place, difficulties still remain with the way in which specific entitlement program policies are developed, and how oversight is conducted to ensure that the implementation and results of those policies are achieving broad social goals and meeting specific programmatic objectives.

Federal influence. As with policy, the influence of the federal government significantly complicates the state's ability to oversee and manage entitlement programs. Most of the large entitlement programs that fall within the scope of this study are federally initiated but administered by the state. The federal government establishes the broad policy and statutory requirements, the programmatic mandates, the options states may choose, and imposes regulatory requirements concerning how the states must operate the program.

The federal government does allow substantial leeway in terms of benefits and payment levels that states may offer. However, as noted in the previous chapter, in the AFDC and State Supplement programs, the federal government has established benefit floors tying the benefits a state must pay to whatever those benefits were for a particular year. A state may raise its benefit levels from that floor, but a state risks federally imposed financial sanctions if benefits are cut to a point below the established floor. For example, the state cannot cut AFDC payment levels below those of May 1988.

Even so-called "optional" programs are not exempt from federal control. Connecticut's State Supplement program -- which augments the income of aged, blind or disabled persons -- now provides coverage once considered optional by the federal government. But, through federal regulations, Connecticut must demonstrate that it is maintaining its fiscal effort at supporting this program, either through spending at least what it did the year before, or by ensuring that each recipient is receiving at least the same supplement he or she was receiving in the previous year. If a state fails to demonstrate these fiscal efforts, federal Medicaid payments to the state are at risk.

One of the effects of this strong federal influence is that state agencies administering these programs are frequently perceived, even to state lawmakers, as arms of the federal government rather than implementers of state policy.

Another obstacle to policy oversight of entitlement programs is that little that governs them is addressed in state statute. Most eligibility criteria, benefit levels, and other guidelines for operating the large programs are addressed in policy manuals or regulations. In DIM's case the manuals are in regulation. This is because entitlements are so subject to change, and there is a need for flexibility in programs that have federal control. The program review committee believes it would be unwieldy to put all governing policies for entitlement programs in statute. However, it must be recognized that a substantial amount of what is happening with these programs is occurring without the direct knowledge or input of the state legislature.

Information and Communication

State policymakers need more and better information about entitlement programs, if they are to manage these programs, know what drives them, and shape policy to control them. The information presented in an earlier chapter on program descriptions provides a framework for policy choices within each of the entitlement programs, but it is a snapshot of the programs as they currently exist. Policymakers also need more information about where entitlements are going, and how effective they have been. It is crucial they know what the federal government is doing, or planning to do, with entitlements.

The program review committee believes that linkages between the federal agencies, congressional offices, and state policymakers are weak, and are focused on the state executive branch agencies expected to implement the programs rather than on the state legislature. For example, the secretary of the Office of Policy and Management is required to "advise the governor regarding potential federal actions affecting state government and the citizens of the state, including the allocation of resources in the federal budget, federal economic policy, and the distribution of federal assistance and facilities among regions and states." (C.G.S. Sec. 4-66a(b)) There is no similar requirement that the secretary advise the legislature as well.

The Legislative Program Review and Investigations Committee recommends that the state begin to establish a better link between state policymakers and their federal counterparts so that federal policy initiatives are conveyed to all branches of state government as soon as possible. In addition, Section 4-66a(b) of the Connecticut General Statutes should be changed to require that the secretary of the Office of Policy and Management advise the legislature through the Appropriations Committee and the chairmen of the committees of cognizance of such federal policy initiatives.

Some administrative ways the program review committee suggests state legislators and their staff establish those links are: 1) foster closer ties with Connecticut's Congressional delegation and staff; 2) improve tracking of any proposed federal legislation or regulations to provide the information to appropriate legislators; 3) generate and maintain links with national

organizations, such as the National Conference of State Legislatures (NCSL), and the Council of State Governments, that closely monitor federal developments; and 4) use publications such as the Hall of the States Mandate Watch List, which is issued monthly through NCSL, to track proposed federal legislation that would affect states.

Better policy development and oversight will require increased participation and cooperation among a variety of governmental agencies at the state and federal levels. The agency administering the entitlement program, other state agencies, the Office of Policy and Management, the legislature, and its staff as well as federal agencies and Congress all need to improve their communications about entitlement programs.

Most of what is suggested above could take place on an informal basis. However, program review believes that more formal devices also need to be put in place to convey policy changes in entitlement programs and provide oversight. They include: policy impact statements; more input into the state planning process; better data; and improved budget oversight and controls.

Impact statements. Without a formal notification of a policy change, there are no assurances that legislators have received the necessary information. Thus, **the program review committee recommends that any state agency proposing a change -- legislative, fiscal or program policy -- that would affect the entitlement programs identified in this study, issue an impact statement to the committee of cognizance and the Appropriations Committee, as well as other executive agencies involved, outlining the policy being proposed. This should be submitted in one of the three following ways:**

- **with the agency's budget requests, for a policy that will need legislative action and/or appropriation;**

- **with the proposed regulations, if the policy must go through the regulatory process; or**

- **at least 60 days prior to an adoption of program policy, where legislative or regulatory approval is not necessary.**

Such a statement would have to be submitted with any new policy that would affect entitlement programs, whether the result of federal mandates, options, or state agency proposals. Recently, P.A. 90-124 required state agencies -- as part of the Uniform Administrative Procedure Act -- to notify the committees of cognizance of proposed regulations with a fiscal note. In the Department of Income of Maintenance, policy manuals are adopted through the regulatory process, and thus most policy changes may be covered by this requirement. However, this would not be the case with program policies in other agencies.

Also, the impact statement would go beyond solely notification purposes, and require departments to focus on: what the policy is intended to achieve; the impact on caseload, program

usage, and expenditures on the program; any ripple effect on other programs; and how the state's social policy goals would be furthered with such a strategy. The impact statement should analyze how the policy would specifically achieve a social policy goal such as attaining self-sufficiency, keeping families together, and/or reducing poverty.

The impact statement would enhance oversight of entitlements in several ways. First, it would strengthen the legislature's involvement in the formulation of policy, which would be especially helpful when a federal option is being proposed that the state may or may not choose. Where no choice is available because the federal government is mandating -- through legislation or regulation -- that the state adopt a policy, state legislators ought to be aware of that too. State policymakers must recognize there is a cumulative impact of federal mandates on state programs. The greater that impact on both program policy and resources devoted to it, the less role state policymakers have in shaping programs or in controlling resources.

Further, the impact statements could be reviewed by legislators and their staff, with independent research and verification if necessary. If the impact statement were analyzed prior to public hearings, or budget discussions, legislators would have more opportunity for weighing the implications of policy choices. The submission of the statements would also create an additional forum to elicit public input on the policy proposal, if the legislature chose to hold a hearing, workshop, or the like.

Finally, the impact statement provides an additional oversight tool by which the legislature can measure program performance. For example, if data collected and reported by the department indicate the anticipated or stated impact is not being achieved, the legislature could recommend or adopt remedial action.

State plans. Another way to improve oversight of entitlement programs is through the state planning process. The state Department of Income Maintenance must develop and submit state plans to the federal government for its approval to operate and receive federal reimbursement for AFDC, Medicaid, and the JOBS program. A state plan must be resubmitted if a change is made or to inform the federal government of how the state will operate a new federal mandate or option. Important policy options are incorporated as part of the state's plans for these programs. A number of them were adopted so long ago that there is even little institutional memory as to why they were chosen.

The state legislature is not involved in developing the state plans, nor does the department solicit input from the legislature or the public through hearings on a plan. It is akin to a contract between the state agency and the federal government. Program review staff believes the state plan for any of these programs is an important vehicle for outlining how the state will operate that particular program, and that its development and submission ought to be done as openly as possible.

Therefore, the program review committee recommends that the Department of Income Maintenance hold public hearings on the state plans for AFDC, Medicaid, and the

JOBS program at least once every three years, and that the department notify the committee of cognizance of those hearings.

Waivers. Another method that the Department of Income Maintenance, as administering agency of the federally required public assistance programs, can use to change policies concerning entitlement programs that have federal involvement is to request a waiver from the federal government. An agency is required to request such a waiver if it wished to operate its program differently than the federal requirements, absent the availability of a program option. The process for submitting waiver requests is outlined in Chapter II of this report. As noted, there is a state statutory requirement that any waiver request that DIM proposes to the federal government first be submitted to the Human Services and Appropriations Committees of the General Assembly for approval.

The Legislative Program Review and Investigations Committee believes that the prior submission to the legislature for approval is cumbersome and unnecessary. The committee members believe that submission to the legislature first may hamper department efforts at innovative changes in programs that would require waivers. But program review members also want to ensure that the legislature is informed of such waiver requests. Therefore the following recommendation includes a measure to ensure that such information is provided.

The Legislative Program Review and Investigations Committee recommends that Section 17-2k(a) of the Connecticut General Statutes be amended to remove the requirement that the commissioner of the Department of Income Maintenance submit an application for a federal waiver of any assistance program to the committee of cognizance for human services and the appropriations committees of the General Assembly, prior to submitting the applications to the federal government. Instead, the commissioner will be required to notify the legislative leaders of the submission of the application to the federal government.

Adequate data. Improved oversight of entitlement programs will also depend on adequate data. Once the information to develop policy has been provided, the legislature also needs to know how the entitlement programs are being implemented, and what results they are producing. Program review believes there is a lack of well-developed, management information systems that provide policymakers the kind of information they need to perform this type of oversight.

For example, the Department of Income Maintenance directs most of its information system efforts at determining client eligibility for benefits, and detecting fraud, abuse, and other payment errors. In other words, DIM's priority for its information systems is to support its accounting function and reflects the department's emphasis on accurate and timely payments.

The other focus of DIM's information systems is to respond to federal requirements. The department's programs are largely driven by a myriad of federal regulations. With the growth in the number of federal mandates, reporting and monitoring requirements have also increased.

Thus, with limited staff and resources, the department responds first to the federal government because of its ability to withhold money.

State policymakers must demand that departments operating entitlement programs collect and provide the information necessary to help in policy development, and evaluate policy choices after they have been made. This means not only the number of clients served, how quickly they are served, and the total amounts received, but data that monitor whether particular policies are achieving the outcomes expected -- self-sufficiency, client responsibility, or economic well-being until self-sufficiency can be obtained.

There is already a recognition by the legislature that improved access to data and its reporting are needed to make better policy decisions. The legislature appropriated funds to hire a consultant to examine the Department of Income Maintenance's computerized systems and propose where data could be better collected, used, or analyzed. The consultant produced a report with a great number of recommendations toward those ends; implementation of the recommendations may depend on available resources.

The General Assembly also strengthened the performance monitoring requirements with which state agencies must comply. Public Act 92-8, passed during the May Special Session, mandates that state agencies "develop, for state budgeting purposes, specific biennial goals and objectives and quantifiable outcome measures, which shall not be limited to measures of activities, for each program, service or state grant administered or provided by such agency."

Budget controls. The program review committee has cited some of the areas where, because of federal influences and lack of clear social policy, state legislators may have lost control and management of entitlements. An area where the legislature could exercise greater authority is to fully exercise the budget controls available, including removing the statutory automatic increases in the benefit payment levels.

As noted in Chapter I of this report, what sets entitlements apart from other programs is that they are not limited to an established appropriation. Instead, programs are managed through changes in policy concerning who is eligible, how benefits are determined, and the like. As cited above, a few of these policies are established in law but many are not. It becomes all the more important for legislators to exercise policy oversight and analyze where policies are linked to increasing costs. The state's change to biennial budgeting, providing every second year for review rather than budget adoption, should provide legislators more opportunity to exercise that oversight.

A direct budgetary control mechanism available to legislators is the cost-of-living increases with public assistance programs. In 1988, the General Assembly passed P.A. 88-201 requiring the commissioner of income maintenance to increase benefit payment levels for all major public assistance programs by the same percentage as the increase in the Consumer Price Index, but no greater than five percent.

Only four other jurisdictions -- Alaska, California, Vermont, and the District of Columbia -- have such an automatic cost-of-living adjustment for their AFDC programs.[18] For the FYs 88 through 91, Connecticut increased its AFDC assistance payments a total of 14.9 percent, while the average nationwide for the period was 10 percent.

Even though there is a statutory requirement to provide this automatic increase, for the past two years, the General Assembly has not appropriated the money necessary to fund the increases. Thus, the level of benefits for any of the cash assistance programs has not increased since July 1990.

Program review believes there are few fiscal controls that state policymakers can exercise with entitlement programs, especially those that are federally initiated. The full legislature should not choose to pass up one of the remaining financial checks it has at its disposal.

Therefore the program review committee recommends that sections 17-2(b) and 17-12f be amended to remove automatic increases to benefit payments.

This change would allow legislators authority to exercise a financial oversight and control mechanism in a number of ways. It would provide an opportunity to compare benefit levels among programs and decide whether all programs should be increased by the same amounts. Legislators could also examine how the increases might affect the state's fiscal condition in relationship to federal maintenance of effort provisions.

Further, when cash benefits -- which are not federally reimbursable under the State Supplement or General Assistance, and 50 percent reimbursable under AFDC -- are increased, the client is eligible for less Food Stamps, which are 100 percent federally reimbursable. Thus, state policymakers may examine increased cash benefits in light of maximizing federal funds. Finally, further increasing benefits levels, while other factors in the economy like minimum wage stay the same, fosters economic disincentives to self-sufficiency.

FOCUS OF ENTITLEMENTS: SELECTED ISSUES

The administration of entitlement programs falling under the scope of study is not confined to one agency. Seven of the 12 programs or subprograms are administered by DIM, while the other 5 are administered in 5 separate agencies. This last section of the report concentrates on the Department of Income Maintenance and the programs it administers since that department does operate the bulk of the entitlement programs both in terms of caseload and expenditures. The committee makes a number of findings concerning the focus on the

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[18] Congressional Research Service. AFDC: Needs Standards, Payment Standards, and Maximum Benefits, Washington, D.C., updated November 1991.

entitlement programs DIM operates, including an emphasis on the income support function and the attention given to client self-sufficiency, welfare dependency, and prevention efforts. Some of these issues are related to DIM administration, while others are due to larger policy questions outside of DIM's authority. The committee makes three recommendations to improve weaknesses in these areas.

Efforts to Promote Self-Sufficiency

Until recently, promoting self-sufficiency was not a stated goal with entitlement programs or with the agencies that administer them. Policymakers responded to a need with a public entitlement program, and meeting that need became the overriding purpose of the program, without emphasis being placed on whether or when the clients should be able to provide that service for themselves.

One of the primary reasons for DIM's lack of attention to self-sufficiency is historically there were no legislative or policy mandate with any of the entitlement programs that required it. When state government was reorganized in 1977, the legislature established the Department of Income Maintenance to determine if persons were eligible to receive public assistance, determine the correct amount of benefits, and make timely payments for as long as the clients were determined to be eligible. The 1977 commission in charge of reorganizing government, better known as the Filer Commission, envisioned a department "resembling an "internal revenue services' type of operation with an emphasis on detection and elimination of fraud and error", rather than on the delivery of social services.[19]

The department's singular focus of income support has changed during the 1980s with the introduction of workfare for General Assistance recipients, and responsibility for advocating self-sufficiency among clients through implementation of the JOBS program. Thus, over the course of the 1980s, DIM has been mandated to expand its role beyond processing applications for assistance to promoting self-sufficiency.

In 1989, the state legislature statutorily reinforced that client self-sufficiency must be a goal for the Department of Income Maintenance. Public Act 89-158 established as part of the administrative duties of the DIM commissioner to establish self-sufficiency as an objective in all the department's programs.

In public hearing testimony before the program review committee on September 22, 1992, the DIM commissioner indicated that:

> [the department's] emphasis for many years has been on, and appropriately,. . . determining eligibility, getting individuals into the system so they can

[19] Report of the Committee on the Structure of Government, December 1976.

> appropriately receive the benefits to ensure the care of their children. At the same time, however, we [DIM] have, over the last couple of years, also been encouraging much more than integration of the eligibility determination: the job readiness referral involvement, much more emphasis and training is going on in the JOBS program.

The commissioner's statement supports the finding of the program review committee -- that the department's steps at encouraging clients to become self-sufficient have historically been weak, that current efforts need bolstering, and that measures taken to date have been driven largely by external policies.

JOBS Program

The most important strategy aimed at making clients self-sufficient is the JOBS program, now required by both the state and federal government. However, the efforts of this program at achieving client self-reliance are not as strong as they could be.

First, one of the four federal options -- Community Work Experience Program (CWEP), a type of workfare for AFDC recipients mandated to participate, was not chosen in Connecticut. Connecticut is one of only nine states that is not providing CWEP or an alternative work experience program for its AFDC recipients.[20] Thus, one of the prime mechanisms for developing client responsibility was not utilized.

Second, the primary focus of all DIM's assistance programs is to determine eligibility and establish benefit levels, and not to assess what obstacles there are to client self-reliance. In fact information needed to gauge that -- like education level, skills, or language barriers -- may not be collected for months, even years, until the client is assessed for the JOBS program.

Third, the JOBS program has had limited success in terms of the ultimate goal of getting people employed. Due to limited resources and staff, and administrative difficulties, the department indicates that it has been able to serve only a small percentage of clients and that a substantial number are waiting to participate. Thus, only about 7,151 AFDC clients are currently being served. But only 1,834 (25 percent) of those are in activities that lead directly to employment -- on-the-job training, job search, and job readiness. The other 75 percent (5,502) are in an educational program like adult basic education, courses for GED (i.e., a high school diploma). One thousand of the 5,502 are enrolled in post-secondary education.

The department appears to be rethinking its approach to the JOBS program. In a DIM memorandum to the Welfare Reform Task Force, the commissioner states the department intends to enhance the operation of the program through:

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[20] 1992 Green Book on Entitlements lists Louisiana, Maine, Massachusetts, Missouri, New Hampshire, Oregon, Rhode Island, and Tennessee as the other states.

- increasing staff to serve more families, (which will allow the state to increase federal funds) coupled with a streamlined process that will enable people who are potentially employable to receive service and avoid being placed on a list;

- a focus on getting jobs for those with basic skills (further education and training could take place while employed);

- specialized employment services and intensive services component for hard-to-place clients; and

- exploring the possibility of contracting out case management services for certain groups of clients.[21]

Beyond the focus of the department, state policies must be examined to ensure they provide incentives for clients to work. Currently, the statutory goal for the JOBS program is to "assist participants to find and keep unsubsidized employment, to attain economic self-sufficiency and permanent removal from AFDC." (C.G.S. Sec. 17-485) Program review believes this is a laudable long-term goal, but it may not be achievable in the short-term, nor correspond with the abilities of the client population that JOBS is expected to serve.

The Legislative Program Review and Investigations Committee therefore recommends that the statutory goal of the JOBS program be expanded to include a short-term goal aimed at "reducing the level of assistance needed, by helping the client obtain employment".

The committee believes that state policy for obtaining self-sufficiency with the JOBS program should be varied, allowing for the diversity in education, skills, and backgrounds of the population it serves. It should emphasize obtaining and keeping immediate employment for the short-term, where that is deemed most appropriate, while helping to establish longer-term goals that the client can pursue incrementally. This policy change would provide greater opportunity to encourage the client to demonstrate some measure of self-sufficiency, even at the risk of being dependent on smaller assistance amounts, maybe for a longer period of time.

Lack of Incentives

In addition to the limitations already discussed, there are other obstacles that stand in the way of clients becoming self-sufficient. Below are some examples of where incentives or disincentives may be associated with state policy.

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[21] Memorandum from Commissioner Rowe to Welfare Reform Task Force, November 18, 1992.

Medical benefits. One of the primary reasons studies cite for recipients not leaving cash assistance programs is that Medicaid is automatically tied to the recipient's income assistance. Once the person becomes ineligible for the cash assistance, he or she is no longer automatically eligible for the medical program. The General Accounting Office found in a recent study that about 35 percent of poor single mothers would probably not get health insurance in the jobs they could be expected to find.[22] As long as health care is tied to receipt of cash assistance, there is a deterrent to becoming independent of welfare. Clearly policymakers must consider this link with the difficulty in reducing cash assistance caseloads.

Income incentives. There are some indications that Connecticut's AFDC program may foster disincentives to working. According to DIM data only 10 percent of the AFDC caseload in Connecticut has countable income, meaning that those recipients have money coming into the household from any source that must be subtracted from the need amount. According to recent data Connecticut reported to the federal government, only 5.7 percent of AFDC recipients have any earned income through wages (earnings above $265 a month would be counted for a working mother with maximum day care expenses for one child after one year). Only 11 other states and territories have lower percentages of client caseload with earned income. Thus, in Connecticut the data appear to indicate that the vast majority of AFDC clients do not work to supplement benefit income.

Automatic benefit increases. Another policy that may serve as a disincentive to working is the indexing of the cost-of-living increases in benefits to the rise in the Consumer Price Index. (As noted earlier, these increases have not taken effect in either 1991 or 1992.) However, when public assistance benefits rise to keep pace with consumer prices, but the minimum wage does not, the policy contributes to more people being eligible for benefits and fewer people having an economic reason for leaving assistance. A recommendation was made earlier in this chapter to address this issue.

Welfare Dependency

Closely tied to self-sufficiency is the issue of how policies should be developed to avert long-term welfare dependency, especially in the AFDC program. The program review committee believes Connecticut is far from developing such policies since the collection of data and the analysis necessary to develop these policies are not being done in any systematic way. For example, as already noted, some of the data important to assess the likelihood of long-term welfare dependency -- like education or work experience of the AFDC clients -- are not even being collected at intake. Those factors are not examined until the client is assessed for the JOBS program.

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[22] General Accounting Office. Mothers-Only Families: Low Earnings Will Keep Many Children in Poverty, Washington, D.C., April, 1991.

There is also a lack of attention being paid to demographic data of Connecticut's AFDC caseload, examining the data for predictors of welfare dependence and developing strategies to reduce dependency. For example, the rate of multi-generational welfare cases in Connecticut is not analyzed, and the department does not track whether a parent in an AFDC case was the child in an AFDC case.

In other instances, the data are collected, but are not evaluated to gauge any correlation between what the data show and welfare dependence in Connecticut. For example, studies have shown that one of the strongest predictors of long-term welfare dependence is marital status, with women who were never married most likely to end up on welfare for longer periods. One study indicated that almost 40 percent of the women who have never been married when they begin to receive AFDC will have total welfare time of 10 or more years. Unmarried mothers become trapped in long-term welfare dependency: they work less, they receive less child support, and they are less likely to marry and stay married to someone able to support them and their children.[23]

The program review committee believes the results from these studies have serious future implications for Connecticut's AFDC program. Data from quality control samples in Connecticut -- about 1 percent of the caseload taken from April to September 1991 -- reported to the federal government show that in about two-thirds of the cases the child is deprived of the father's support because the mother has never married, while the remainder resulted from separation, divorce, unemployment, or death.

The latest national data for 1990 measuring this "reason for deprivation" statistic in 52 jurisdictions shows that Connecticut ranks 8th highest in terms of the percentage of "never-marrieds" as a portion of its AFDC caseload.[24] Of more concern is the increasing rate of "never-married" women on public assistance. In 1979, 45 percent of the AFDC cases were receiving assistance because the parents were not married; by 1987 this had risen to 61.5 percent, and in 1991 "never-married" was cited as the reason for deprivation of support in 66.3 percent of the cases, an increase of almost 50 percent in 11 years.

At the federal level, Congress also is recognizing that measurement, analysis, and reporting of data concerning welfare dependence are important. Senator Daniel P. Moynihan (D.- NY) earlier this year introduced a bill in the U.S. Senate that would have required the Health and Human Services Department to begin collecting such data. The program review committee believes the need for this type of information is no less important at the state level.

Therefore, the program review committee recommends that as part of the performance measures required under Public Act 92-8 of the May 1992 Special Session, the

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[23]David Ellwood, and others, cited in the Green Book on Entitlements, 1992, pp. 683-686, and Douglas Besharov, "Targeting Long-term Welfare Recipients" in Welfare Policy for the 1990s, pp. 151 and 152.

[24] 1992 Green Book, pp. 683 and 684.

Department of Income Maintenance develop a series of indicators aimed at measuring the degree of welfare dependency in Connecticut, indicate what those rates are, and identify objectives geared to reducing such dependency.

The Department should collect data on and analyze such indicators as:

- the annual percentage of unmarried women on public assistance and the annual rate of increase;
- the overall rate of out-of-wedlock births in the state;
- the number of second and third generation AFDC recipients;
- the number of births occurring to women while on assistance, and tracking their time on assistance; and
- the previous employment status of the AFDC parent or parents.

Prevention and Family Planning Efforts

The Department of Income Maintenance is required by the federal Social Security Act to have an approved plan for providing family planning counseling to families receiving AFDC (42 USCA § 602(15)(A)(7)). The plan must contain provisions for preventing or reducing the number of out-of-wedlock births by offering family planning services to all individuals and families and providing the services to those who voluntarily request them. It may not link eligibility for assistance with acceptance of family planning services. DIM has not developed such a plan. The policy of the department is to refer clients who request such services to appropriate agencies or programs.

One obstacle that prevents AFDC families from attaining self-sufficiency is the birth of additional children. Studies have indicated that greater numbers of children correlate with longer periods on welfare. Other studies also indicate that children of AFDC households who become parents have a greater risk of becoming dependent on welfare for support. The added cost of child care and health insurance for additional children makes it more difficult for families to leave AFDC assistance and places an added burden on the state to support them.

The department keeps statistics on the number of persons added to any AFDC case that results in a cash benefit increase. The number of persons added during FY 91 was 29,675, while the number for FY 92 was 20,631. According to DIM, the figure for FY 91 may be slightly high due to the department's conversion to a new data processing system, while FY 92 figures may be too low due to report problems.

Earlier, in response to a data request, the department had estimated 80 percent of these added persons represented the number of newborn children for AFDC households -- both those first-time births, and those with additional births -- and the remaining 20 percent was due to persons being added to AFDC households for other reasons, such as children returning from foster care. In its findings and recommendations report, program review had calculated the numbers of additional births using the added person report data, and the department's estimates.

Since the findings and recommendations report was issued in December, the department has revised the information on additional births, after conducting a special examination of its computerized information on birth dates and AFDC grant dates for the last fiscal year. The department indicates that the results of that analysis show that there were 2,611 additional births to already existing AFDC cases during FY 92. However, the department has not revised the total number of additional persons added to AFDC cases during that period, and has not provided an accounting of the reasons why those persons were added.

Beyond the number of additional births that are occurring, the lack of a plan to promote family planning and birth control is evidence the department has not recognized its importance in helping end an AFDC family's dependency on welfare. The absence of a plan is also evidence that DIM is not fully aiding its clients in leaving assistance and becoming self-sufficient.

Family planning is one of the most important factors in determining if an AFDC family will gain control of its future and attain self-sufficiency. DIM has the capacity to aid AFDC families in leaving assistance by becoming more proactive with regard to family planning and birth control for its clients. The department should also take the initiative in providing birth control counseling to second generation assistance recipients, and to children of AFDC families who may have the potential to become sexually active. This would: 1) help them maintain their independence and avoid the responsibilities of parenthood until they were able to attain self-sufficiency; and 2) combat the potential for an AFDC family entering a second generation of reliance on AFDC assistance.

Therefore, **the program review committee recommends that the department develop a plan for preventing out-of-wedlock births.**

The plan could contain components for having caseworkers refer clients to family planning services upon intake or at redetermination. Caseworkers could also make clients aware that contraception is available to AFDC families under Medicaid and encourage clients to utilize this benefit. The department should also encourage AFDC households with children who may be sexually active or potentially sexually active to have their children receive birth control counseling and, where appropriate, contraceptives. Healthtrak (EPSDT) program caseworkers could also participate by referring parents of children receiving services to family planning services. The department should emphasize to its clients the empowerment that family planning and birth control will give to a family seeking to become self-reliant and the difficulties additional children will place on a family that wants to attain this goal.

The promotion of family planning and birth control could be facilitated by the new Department of Social Services. The provision of social services has not been a DIM mandate, but the new department could assume the dual roles of providing assistance and a social work component by offering family planning and prevention counseling services to AFDC families, in addition to assistance. The social work component would allow the department to address the issues of responsible behavior for its clients while it aided them in becoming self-sufficient.

The new department could also combine the services offered by the different state agencies under its umbrella to offer comprehensive services designed to assist AFDC families in escaping from a cycle of poverty. The department might also coordinate its services with those offered by the new Department of Public Health and Addiction Services and expand the level of potential services that would support a family in leaving assistance.

APPENDICES

APPENDIX A

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APPENDIX B

Table B-1. Recently Approved State AFDC Demonstration Projects	
State/Title	Main Features
Wisconsin *Parental and Family Responsibility (PFR).*	• Focused on AFDC applicants and recipients under age 20 with less than 2 children. • Limits additional benefits when another child is born: half the usual grant for next child, and nothing extra for any additional children. • Increases earned income deductions and takes away time limit. • Expands AFDC eligibility for young married families by eliminating some requirements under the AFDC-UP program. • Allows stepparent option to be treated as member of AFDC unit. • Provided for alternative participation under JOBS (waiving JOBS participation requirements). • Requiring noncustodial parents to participate in JOBS.
Wisconsin *Two Tier AFDC Benefit*	• Eligible new recipients will receive their previous state's level of benefits for 6 months (higher or lower) (effective 7/1/94).
Oregon *JOBS Waiver Project*	• Expands JOBS participation requirements.

Table B-1. Recently Approved State AFDC Demonstration Projects	
State/Title	Main Features
Missouri *People Attaining Self Sufficiency*(pending)	• Mandates school attendance by AFDC children and teen parents until they receive high school diplomas or GEDs. Sanctions to be used as last resort; students are require to attend at least 80 percent of time.
Utah *Single Parent Employment Demonstration Program*	• Self sufficiency planning to begin when family applies for assistance--before interview with eligibility case manager. • Institute system of one-time payments and services to divert families from assistance (transportation, child care). • Use procedures for fast tracking certain populations and "prioritizing workloads based on self-sufficiency and collection criteria. • Noncustodial parents may participate in JOBS. • Eliminate JOBS target groups or exemptions. • Increases the earned income disregard and eliminate time limits. • Eliminates transitional benefit requirements. • Optional food stamp cash-out.

Table B-1. Recently Approved State AFDC Demonstration Projects	
State/Title	Main Features
California *Welfare Reform Demonstration Project.* purposes, including coverage under Medicaid	• Families moving to California for first 12 months would receive the lesser of either California AFDC payment or the payment of the state from which they moved. • Reduced grants by 10 percent and an additional 15 percent for those on AFDC for over 6 months. (Obtained waiver for maintenance of effort provision) • Cal Learn: Pregnant and parenting teens who have not completed school are required to attend school or a training program as a JOBS activity. A $50 bonus is given to those who comply with monthly attendance requirements; a $50 sanction is applied to those who do not. • Eliminates sanctions for failure to continue participation in JOBS. • Eliminates time limits for earned income disregard. • Eliminates 100 hour rule for AFDC UP • No additional AFDC payments for children conceived while the father or mother is receiving AFDC. (These children are considered AFDC recipients for all other purposes)
Virginia *JOBS and Child Support Program* (pending)	• Allow continued eligibility for Medicaid, child support, and support services after AFDC case is closed due to child support payment.

Table B-1. Recently Approved State AFDC Demonstration Projects	
State/Title	Main Features
Maryland *Primary Prevention Initiative Demonstration Project*	• Provides special needs allowance for nutritional needs in last four months of pregnancy. Anyone eligible for special need who does not receive prenatal care subject to sanction of $14 month. • Anyone who did not receive annual health check up would be sanctioned $20 per year per person. • Families not meeting minimum Early Periodic Screening, Diagnosis, and Treatment (EPSDT) standards will be subject to a $25 per month sanction for each child not meeting standard. • Families whose children attend school less than 80% of the time without good cause will be subject to a sanction of $25 per month per child.
Michigan	• Eliminates 100 hour rule and recent connection with workforce rule for AFDC-UP. • Increases and eliminates time limit for the earned income disregard. • Income earned by dependent child who is student will be disregarded as both income and assets. • Noncustodial parent may participate in JOBS program. • Eliminates JOBS requirement to give first consideration to target group volunteers. • Eliminated extended job search limit under JOBS.

Table B-1. Recently Approved State AFDC Demonstration Projects	
State/Title	Main Features
New Jersey *Family Development Program*	• Expanded JOBS participation requirements. • Eliminates requirement that the state operate a conciliation process to resolve disputes before sanctioning. • Denies benefits for additional children born more than 10 months after AFDC application. • Provides enhanced earnings disregards for families affected by family cap. • Change in treatment of families with stepparents. • Medicaid transition extended from one year to two.
Source: Center for Law and Social Policy (9/4/92 Draft)	

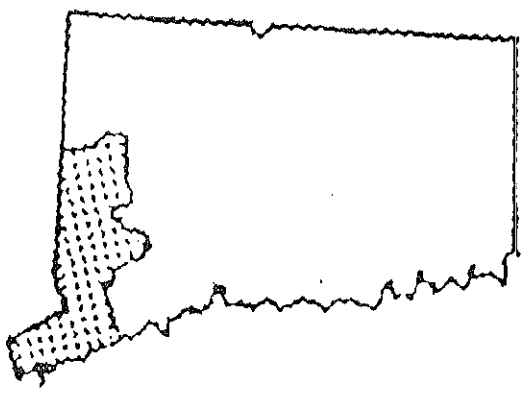
APPENDIX C

AFDC: COMPONENTS OF STANDARD OF NEED

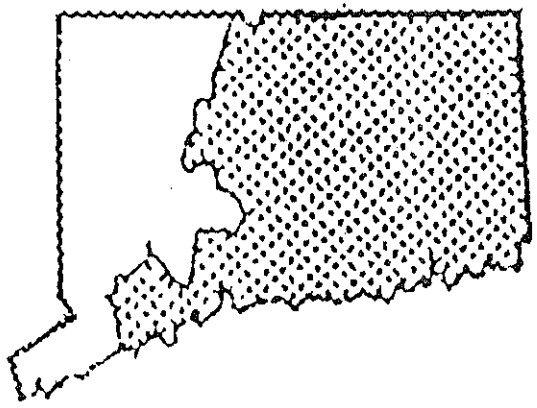
INCREASE OF AFDC COMPONENTS																
Family Size	Food	Clothing	Personal	Household Supplies	Cooking Fuel	Electric	Water Heat	Fuel Heat	Special Needs	Subtotal	RENT			TOTAL		
											Reg. A	Reg. B	Reg. C	Reg. A	Reg. B	Reg. C
1	91.36	18.34	11.82	3.83	4.37	7.82	3.71	15.92	17.66	174.83	256.00	182.00	182.00	430	356	356
2	160.78	32.38	16.78	5.41	6.60	11.48	5.70	22.86	30.51	292.50	257.00	181.00	181.00	549	473	473
3	202.67	47.51	22.12	6.61	9.37	13.20	9.19	34.81	39.24	384.72	296.00	197.00	189.00	680	581	573
4	249.54	62.64	27.53	6.39	8.23	12.61	12.61	37.25	46.97	463.77	329.00	220.00	202.00	792	683	665
5	302.98	77.79	32.92	8.01	8.29	12.65	12.65	37.28	63.32	555.89	338.00	226.00	202.00	893	781	757
6	360.70	92.94	38.28	9.61	9.15	12.91	17.25	41.47	69.49	651.80	348.00	233.00	209.00	999	884	860
7	430.09	106.07	43.71	11.20	10.83	15.37	20.00	49.72	78.00	766.99	345.00	231.00	200.00	1,111	997	966

APPENDIX D

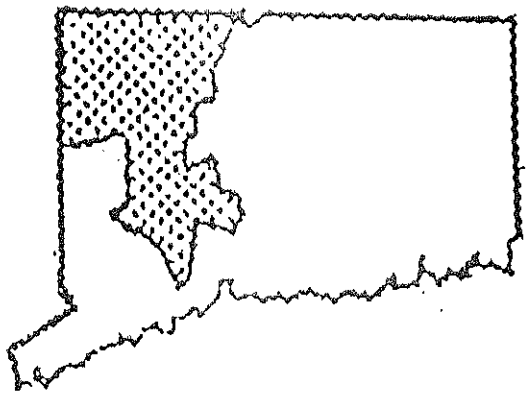
AFDC RENT REGIONS IN CONNECTICUT



REGION A



REGION B



REGION C

Source: Department of Income Maintenance

APPENDIX E

COST OF BENEFIT METHODOLOGY

The average costs of providing service to an AFDC family for each of the programs is described in detail below, as well as the methodology used to determine the amount.

Cash assistance. The amount of cash assistance an AFDC family receives depends on the family size, the region of the state, and other sources of income. The most common AFDC unit is comprised of two members, but the average size is 2.8 members. For this analysis, program review used the average monthly payment made in the state of $570, or $6,840 a year.

Medicaid. All of the families on AFDC automatically receive Medicaid coverage. Not all families use their medical coverage, and, of course, there can be wide variances in medical expenses. The data to assess variance of use are not available from DIM. The FY 92 Medicaid expenses for AFDC cases are not available so program review committee staff used FY 91 expense data for this analysis. In FY 91, the average cost for an AFDC family that used medical services was $325 per month or $3,900 a year.

Food stamps. Most of the families (88 percent) on AFDC also receive food stamps. Since all household income must be considered for food stamp eligibility, some AFDC families living with others may not be eligible. The average monthly food stamp payment for AFDC families is $167 or $2,004 a year.

Housing. From the data collected on Section 8 or state Rental Assistance program rental subsidies, program review estimates that approximately 11,443 (21 percent) AFDC families receive rental subsidies, costing an average of $508 a month, or $6,096 a year.

At least another estimated 13 percent of the AFDC population live in public housing. The average rent paid by the tenants in public housing is about $208 a month or $2,443 a year. There is no subsidy per se in public housing; AFDC tenants must use their AFDC benefit payment for the rent charged. Furthermore, rents collected by the housing authority responsible for operating public housing cover the maintenance and operating costs of the housing. Therefore, there is no additional cost borne by the state. However, program review committee staff recognize that the true value of public housing is higher because rent in the private rental market would more costly.

For those not residing in public housing or receiving rental subsidies, and who spend more than 50 percent of their total income (including assistance) on their rent, the state pays another $50 rent supplement per month, or $600 a year. DIM reports show that about 22,800 (41 percent) AFDC families receive these supplements.

School nutrition programs. Children whose families are below 130 percent of the federal poverty level are eligible to receive free school lunches and breakfasts. Over 800 schools in the

state serve school lunches, while only 134 serve breakfasts.

Based on the number of letters that DIM distributed to AFDC families to certify children as eligible, 78 percent (42,752) of AFDC families are eligible for school nutrition programs. However, not all schools participate in the program; therefore, program review staff assumes that only about half (about 27,500) the total AFDC families are actually receiving school lunches. Based on the number of children in the families that were sent letters. program review staff calculated that the average number of children was 1.5 per family.

Assuming that a student who is eligible eats lunches 170 school days (180 school days - 10 absences), and that the costs of a school lunch is the federal reimbursement level of $1.50 per lunch, the public costs of providing that service to an AFDC family is $382.50 ($255 per child x 1.5 children) per year.

The same children are also eligible for school breakfasts, but there are not as many schools that offer breakfasts as lunches, although most of the larger city schools do. About half of the AFDC population is concentrated in the state's three largest cities. Thus, program review staff estimates that about half the families participating in the school lunch program are also receiving school breakfasts. The free breakfasts cost $.93 each, and assuming each child eats school breakfasts only half the days, the cost of providing that to an AFDC family is $125.55 ($.93 x 90 days x 1.5 children). A combined average cost for both nutrition programs results in a cost of about $424 for about 38 percent of AFDC families.

Special Supplemental Food Program for Women, Infants, and Children (WIC). The Department of Health Services administers the WIC program with federal funds. Infants, children under 5 years old, and pregnant or postpartum mothers whose income do not exceed 185 percent of the federal poverty line ($21,404 for a family of three in 1992) and who are at "nutritional risk" are eligible for the WIC program. Vouchers are provided to eligible recipients to purchase nutritional dairy and food items at participating stores. The average cost per individual receiving WIC is $33.10 per month. The department was unable to estimate how many WIC recipients also receive AFDC.

Energy assistance. The Department of Income Maintenance provides fuel assistance to its clients on AFDC or State Supplement programs. There are different types and amounts of assistance available, depending on the type of fuel used and the type of residence. Families or individuals can receive a maximum basic payment of $545. If that is used, and the client still needs assistance, the department can provide a "crisis" payment of $150. Finally, the client is eligible for "safety net" payments of $150 per occurrence, if the first two types of assistance have been exhausted. Based on the Energy Assistance program data from FY 92, program review staff calculates that 34 percent of AFDC cases receive energy assistance at an average cost of $428 per case.

Job Opportunity and Basic Skills Program (JOBS). The federal government requires that each state offer a job training and education program for its AFDC clients to help them

avoid long-term welfare dependence. There are federal requirements concerning which clients are mandated to participate, targeted groups, and required state participation rates. The program pays for support services like child care and transportation so clients can participate. Payments for those support services totalled slightly over $10 million for FY 92. Currently about 7,151 clients, or about 13 percent of the AFDC caseload, are actively enrolled in the JOBS program. Thus, the costs of the support services for the JOBS program averaged $1,398 per case. These costs for the most part do not cover the expense of the training itself or tuition if the client is enrolled in post-secondary education. About 1,000 of the 7,151 clients are enrolled in post-secondary programs. Federal PELL grants cover the tuition in most cases, although accurate data on the number and amounts to AFDC recipients are not available.

APPENDIX F

AGENCY RESPONSE

STATE OF CONNECTICUT

DEPARTMENT OF INCOME MAINTENANCE

OFFICE OF THE COMMISSIONER

AUDREY ROWE
COMMISSIONER

TELEPHONE
(203) 566-2008

February 1, 1993

Mr. Michael Nauer
Director, Legislative Program Review
and Investigations Committee
Room 506, State Capitol
Hartford, CT 06106

Dear Mr. Nauer:

Thank you for the opportunity to comment on the recommendations included in the Committee's report on entitlement programs. I appreciate the amount of time and effort your staff devoted to this project and believe the report, on the whole, reflects our programs as they are today. I am sending a separate letter to provide program clarifications, most of which have previously been discussed with your staff. For example, in considering the cost of benefits in the State Supplement Program, the amount received from SSI is not included; this additional $5,208 per year makes a big difference. This income, or a comparable amount from another source, is received by every recipient living in the community. In another example, when a minor parent lives with his or her parents, the report states that we do not exercise the option to have the payment go to the parents; in fact we do require that the check go to the parents.

I would like to address several of the recommendations individually. The first, **the development of a broad social policy,** is already being addressed by the reorganization team. This policy will be articulated in the Governor's reorganization bill with our mission and goals. We welcome comment on our proposal.

Impact statements on policy changes are already a part of our budget requests and proposed regulations. Since program policy changes are all made through either legislation or regulation, the third suggested format for such impact statements, that is, sixty days prior to implementing any other program policy changes, is not applicable.

While we welcome public input on all our programs, the suggestion to **hold public hearings on our state plans** does not achieve what we believe to be your intent. State plans are the formal technical agreements between the federal government and the Department for operation of the various jointly funded programs.

Public input and legislative oversight is solicited, and received, long before any State plan changes are submitted to the federal government. Hearings on the state plans themselves would offer legislators and the public little viable input.

I totally agree with the recommendation that **the current "cumbersome and unnecessary" legislative requirement that substantive waivers be submitted to the Appropriations and Human Services Committees prior to their submission to the federal government be eliminated** and that legislative leadership be notified of the submission instead. This procedural simplification would be of great assistance.

The recommendation for **the elimination of the current statutory authorization of automatic annual benefit increases** is inappropriate. The very "direct budgetary control mechanism" mentioned has indeed been used in the past few difficult budget years through legislation directing no increase of benefits for July 1, 1991 and July 1, 1992. The initial legislation authorizing automatic increases for three years was part of the Welfare Reform package in Public Act 85-505. The intent was to assure that basic benefits kept pace with inflation (not to exceed 5% in a given year). This seems particularly appropriate when AFDC benefits are but approximately 60% of the 1993 federal poverty level.

Amending the JOBs program statute alone to include **"helping the client obtain employment"** may be too narrow a modification. It is also not consistent with the federal Family Support Act. However, we are focusing directly on self sufficiency in the Governor's Welfare Reform package and in the Welfare Reform Task Force recommendations as well.

The recommendation that the Department **develop "indicators aimed at measuring the degree of welfare dependency in Connecticut..."** is excellent but feasible only if staff is appropriated to perform this research function. The indicators of dependency identified are, however, too narrow. I am currently working with the General Accounting Office on a national research agenda. This is a great opportunity and will help us immeasurably in Connecticut as we develop strategies for poverty reduction.

Recommending that the Department **develop a plan for preventing out-of-wedlock births** requires a plan which is flawed from the beginning. To the extent that our state plan does not meet the requirements cited in the report, it will be corrected. Reducing out-of-wedlock births, however, is a much broader issue. The solution originates far beyond the jurisdiction of Income Maintenance. The recommendation would more realistically require the State to develop effective programs. These must include adequate school-based education and an expansion of abortion services. A comprehensive statewide effort is needed to effectively promote family planning and responsible parenthood.

Once again, thank you for the opportunity to comment on these recommendations. Surely there will be occasion to discuss them in far more detail in the coming months.

Sincerely,

Audrey Rowe (mm)

Audrey Rowe
Commissioner

AR:mcj